

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Items 18-21 Film 383 11- MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12843

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8704 Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8704 Gilbert Place Apt 1-B</u>				d. STREET ADDRESS <u>8704 Gilbert Pl. Apt 1-B</u>			
3. NAME OF DECEASED (Type or print) <u>Leonard Daniel Adams</u>				4. DATE OF DEATH <u>Sept 9 1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1924</u>	9. AGE (In years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Daniel Adams</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Evans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Evelyn Darrow</u> Address <u>8211 Vinal Pl. S.W. Silver Spring Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> DUE TO (b) <u>Overdosage of narcotics</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased apparently took overdose of morphine, heroin, or both.</u>					
20c. TIME OF INJURY Month, Day, Year <u>12 noon 9-9 19 66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Roberts MD</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John S. Roberts MD</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) <u>Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>		23b. DATE THEREOF <u>Sept 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Burham, North Carolina</u>	
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>				25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Funeral Home <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>							

12/11/51

12/11/51

12/11/51



[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12849

12844

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General				d. STREET ADDRESS 18830 Chandlee Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Doris Gwendolyn Addison				4. DATE OF DEATH Month Day Year 9 21 19 66			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/17/36	
9. AGE (In years last birthday) 30 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel C. Gaither				14. MOTHER'S MAIDEN NAME Mattie Lockman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA + / ANANITION DUE TO ACUTE + CHRONIC OSTEOMYELITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. GANGRENE (NECROSIS) OF PELVIS							INTERVAL BETWEEN ONSET AND DEATH 3 WKS 6-8 WKS 4 WKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARAPLEGIA - MARKED DECUBITAL ULCERATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/22 , 19 66 , to 9/21 , 19 66 , that (I) (we) last saw the deceased alive on 9/21 , 19 66 , and that death occurred at 9:15 M, from causes and on the date stated above.							
22a. SIGNATURE Donald R. Lewis				22b. DATE SIGNED 9/21/66		22c. PHYSICIAN'S NAME (Type) Donald R. Lewis	
22d. ADDRESS OLNEY, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-25-66		23c. NAME OF CEMETERY OR CREMATORY St. Zion.,		23d. LOCATION (City or Town) (County) (State) Mt. Zion, Md.	
24. FUNERAL DIRECTOR George R. Snowden Rockville				25a. REC'D BY REGISTRAR SEP 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

CASE DISCUSSED & CLEARED WITH MED. EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

12-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12850

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12845

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Mary Last Austin		4. DATE OF DEATH Month September Day 26 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1895
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR 7 Months 15 Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Thomas Austin		14. MOTHER'S MAIDEN NAME Martha E. Talbott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Brother		Address Thomas T. Austin Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread metastatic carcinoma DUE TO (b) Carcinoma of large bowel OUE TO (c) Intestinal obstruction			INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 66 , to 9-26 , 19 66 , that (I) (we) last saw the deceased alive on 9-26 19 66 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE James H. Scully		22b. DATE SIGNED 9-26 66	
22c. PHYSICIAN'S NAME (Type) James H. Scully		22d. ADDRESS 1835 Eye St N.W. Wash D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-28-66	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City, town or county) (State) Bethesda, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 27 1966	
		25b. REGISTRAR'S SIGNATURE John J. Judge	

12350

12343

Hospital

Marshall

Hospital

Miss Mary

25 days

Marshall

Marshall

Miss Mary

Marshall

Miss Mary

Female

Feb. 17, 1905

Marshall

Marshall

Marshall

Marshall

Marshall

Marshall

Marshall

12350

Marshall

Marshall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12851

12846

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>50 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7221 Minter Pl</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN + Hosp</u>		d. STREET ADDRESS <u>Takoma Park Md.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET HELEN BARGHAUSEN</u> First <u>MIDDLE</u> -Middle- Last		4. DATE OF DEATH Month <u>9</u> / Day <u>10</u> / Year <u>1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/90</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Orr</u>		14. MOTHER'S MAIDEN NAME <u>Ellen McGillicutty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemic Pneumonia</u> DUE TO <u>4722</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hem. rt. vent.</u> DUE TO (c) <u>Cholera dysenteriae - bloody</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9/6/66</u> <u>9/1/66</u> <u>8/12/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> , 19 <u>65</u> , to <u>Sept 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Howard I. Morse</u>		22b. DATE SIGNED <u>9/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard I. Morse M.D.</u>		22d. ADDRESS <u>3030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept. 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Prince Georges Md</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

15818

RECORDS OF THE

15818

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12852 CERTIFICATE OF DEATH 12847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u> <u>3000 McComas Ave.</u>		d. STREET ADDRESS <u>5904 Onondaga Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>S</u> Middle <u>Barker</u> Last		4. DATE OF DEATH <u>Sept. 28</u> Month <u>19 66</u> Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/83</u>
9. AGE (in years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George C. Barker</u>		14. MOTHER'S MAIDEN NAME <u>Lucy E. Lambert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>579-05-2897</u>	
17. INFORMANT Address <u>Claire S. Adams same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary heart failure</u> 4200 DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1966</u> , to <u>Sept 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 28, 1966</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H F Kreuzburg</u>		22b. DATE SIGNED <u>9/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>		22d. ADDRESS <u>7852 16th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>9/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DATE OCT 3 1966

12413

DEPARTMENT OF HEALTH

12413

TO THE HONORABLE SECRETARY OF THE DEPARTMENT OF HEALTH
WASHINGTON, D. C.
FROM THE DIRECTOR OF THE BUREAU OF VETERINARY MEDICINE
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing a matter related to veterinary medicine, possibly concerning a specific case or a general administrative issue. The text is organized into paragraphs and includes some headings that are difficult to decipher.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12853

12848

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON Sanitarium + Hospital</u>		d. STREET ADDRESS <u>709 Auburn Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>VMN</u> Last <u>BARR</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-95</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>NATHAN RUDOLF</u>		14. MOTHER'S MAIDEN NAME <u>IDA FISHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-50-7258</u>	
17. INFORMANT <u>DAUGHTER</u>		Address <u>709 Auburn Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> DUE TO (b) <u>PERIPNEUMONIC PNEUMONIA</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPOTHYROIDISM & A.S.H.D</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>8-27, 1966</u> , to <u>9-16, 1966</u> that (I) (we) last saw the deceased alive on <u>9-16, 1966</u> and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert B. Cushman</u>		22b. DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GILBERT B. CUSHMAN</u>		22d. ADDRESS <u>6480 NEW HAMM. AVE TAKOMA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-18-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>P.C. Lodge Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Goldberg F.H. 4217-9th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13244

13244

Robert B. Coughlin

X

P-11

8-22

9-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12854 CERTIFICATE OF DEATH 12849

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		<i>15-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>				d. STREET ADDRESS <i>11200 Lockwood Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Portia Imogene Bass</i>		First Middle Last		4. DATE OF DEATH <i>Sept. 23 19 66</i>		Month Day Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 28, 1886</i>	
9. AGE (In years last birthday) <i>79 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Henry W. Moran</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-03-6270B</i>		17. INFORMANT <i>Roscoe H. Bass</i>		Address <i>11200 Lockwood Dr. Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia due to nephrosclerosis</i> DUE TO (b) <i>Congestive Heart Failure</i> DUE TO (c) <i>Myocardial Infarction</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Essential Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>10 days</i> <i>10 days</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Sept 13, 1966</i> , to <i>Sept 23 1966</i> that (I) (we) last saw the deceased alive on <i>Sept 23 1966</i> , and that death occurred at <i>8:30 AM</i> from the causes and on the date stated above.		22a. SIGNATURE <i>John J. Curry M.D.</i>	
22b. DATE SIGNED <i>9/23/66</i>		22c. PHYSICIAN'S NAME (Type) <i>John J. Curry, M.D.</i>		22d. ADDRESS <i>10620 Georgia Ave., Silver Spring, Md.</i>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sep. 27, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		24a. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		24b. REC'D BY REGISTRAR <i>SEP 26 1966</i>		24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

15849

15849

(15)

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

15849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12855

12850

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Annapolis			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 98 Conduit Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilburn Middle BATES Last				4. DATE OF DEATH Month Sept. Day 20 Year 1966			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1886	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (UWK)				14. MOTHER'S MAIDEN NAME (UWK)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1910-1946		16. SOCIAL SECURITY NO.		17. INFORMANT Norwood Address Pennsylvania Mr. Wilburn E. Bates, 105 Trites Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of the oral mucosa with 1919 DUE TO widespread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 8 , 19 66 , to Sept. 20 , 19 66 that xx (we) last saw the deceased alive on Sept. 20 , 19 66 , and that death occurred at 650PM , from causes and on the date stated above.							
22a. SIGNATURE Robert W. Cantrell				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept. 21, 1966	
22c. PHYSICIAN'S NAME (Type) Robert W. CANTRELL, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR John M. Taylor Funeral Home 147-149 Gloucester St., Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

15820

15820

CERTIFICATE OF DEATH

Montgomery

Montgomery

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery

Montgomery

Montgomery

Montgomery

RET

(unc)

(unc)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

Montgomery (Mont)

9-23-66

Montgomery (Mont)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12851
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>720 DARTMOUTH AVE.</u>		d. STREET ADDRESS <u>720 DARTMOUTH</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RUDOLF</u> Middle <u>-</u> Last <u>BAUSS</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 23, 1899</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAT. CAP. PARKS</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM GEORGE BAUSS</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA ECKHARDT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-46-8038</u>	
17. INFORMANT <u>MRS MARGARET BAUSS</u> Address <u>SILVER SPRING</u> <u>WIFE</u> <u>720 DARTMOUTH AVE. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRONCHIOGENIC CARCINOMA METASTASIS</u> DUE TO (c) <u>9 MO'S.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. - 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>66</u> , to <u>SEPT</u> <u>8</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>SEPTEMBER 7, 1966</u> , and that death occurred at <u>9:38 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold W. Draper</u>		DATE SIGNED <u>9/11 SILVER SPRING AVE, S.S. MD 9/8/66</u> <u>585-7518</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER, M.D.</u>		<u>911 SILVER SPRING AVE, SILVER SPRING, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-10-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Home Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Urbington, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		ADDRESS <u>3821-14th St NW, Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>SEP 14 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

12857

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12852

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1935 Kimberley Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Gregory Richard Becker</u>		4. DATE OF DEATH <u>Sept. 2, 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-51</u>
9. AGE (In years lost birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph J. Becker</u>		14. MOTHER'S MAIDEN NAME <u>Meadows, Mildred C.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Stem Lesion</u> DUE TO (b) <u>—</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1966</u> , to <u>Sept 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 2, 1966</u> , and that death occurred at <u>12:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u> M.D.		22b. DATE SIGNED <u>Sept. 2, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept. 6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lack Creek</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
ADDRESS <u>257 Carroll Street N.W. Washington, D.C. 20012</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1988

CELEBRATE DE DEATH

1988

Hold Cross Hospital
Gregory Richard
1988
1-2-81

Ralph J. Becker
Meadows

1988

1988

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12853

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>	
c. LENGTH OF STAY IN 1b <u>5 min.</u>		d. STREET ADDRESS <u>900 Ashland Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice Camaler Behrendt</u>		4. DATE OF DEATH <u>September 22</u> 19 <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John V. Camaler</u>	
14. MOTHER'S MAIDEN NAME <u>Alice T. Stone</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Norbert L. Behrendt</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>50 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> to <u>9/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/22</u> 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Barber</u>		22b. DATE SIGNED <u>9/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Barber</u>		22d. ADDRESS <u>Sandy Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-24-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1966</u>	
ADDRESS <u>Laytonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12453

12453

Home

Mr.

London

900 Avenue St.

Aug. 1, 1890

White

U.S.

Mr.

Home

H. White

Alice T. Stone

John V. Camilleri

Mr. Robert L. Bennett

No

Washington, D. C.

Glennwood

9-24-90

Serial

Samuel H. Barber, Fayetteville, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12854

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Rhode Island b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital,		d. STREET ADDRESS 12 Division Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ellen Last BENJAMIN		4. DATE OF DEATH Month Sept. Day 22 Year 19 66	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1966
9. AGE (In years last birthday) — yrs.		10. IF UNDER 1 YEAR Months 1 Days 36 Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Newport, Rhode Island		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Benjamin		14. MOTHER'S MAIDEN NAME Anna Pronti	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Newport, Rhode Island		Address Island Mrs. Richard Benjamin, 12 Division St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that it (this hospital) attended the deceased from Sept. 10, 1966 , to Sept. 22, 19 66 that it (we) last saw the deceased alive on Sept. 22, 19 66 , and that death occurred at 1210M , from causes and on the date stated above.			
22a. SIGNATURE <i>Jerry J. Tomasic</i>		22b. DATE SIGNED Sept. 23, 1966	
22c. PHYSICIAN'S NAME (Type) JERRY J. TOMASOVIC M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-24-66	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	23d. LOCATION (City or Town) (County) (State) Horsehead, New York
24. FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 27 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12251

RECEIVED OF DEATH

12251



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Transit & Nursing Home</u>		d. STREET ADDRESS <u>7903-Lockney Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Sol.</u> First Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Warsaw Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chaim Berlin</u>		14. MOTHER'S MAIDEN NAME <u>Chana Silverstone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-078942</u>	
17. INFORMANT <u>MRS. Gussie Berlin - W. Fe. - as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Cardio-Vascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 to <u>Sept 29</u> , 19 <u>66</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Sept 29</u> 19 <u>66</u> , and that death occurred at <u>730 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u>		22b. DATE SIGNED <u>9/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d. ADDRESS <u>8484 16th ST. S.S. Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-2-66</u>	23c. NAME OF CEMETERY OR CREMAORY <u>MT. LEBANON CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD.</u>
24. FUNERAL DIRECTOR <u>B Samposky</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u>	
ADDRESS <u>3501-14th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12851

12856

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 hours		d. STREET ADDRESS 4202 Hollin Ferry Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Lee Last BERRY		4. DATE OF DEATH Month September Day 22 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1937
9. AGE (In years last birthday) 28 28 yrs.		IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett Berry		14. MOTHER'S MAIDEN NAME Pauline Withrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1955-1964		16. SOCIAL SECURITY NO. 520 40 5061	
17. INFORMANT Baltimore Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 451X DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 22, 1966 , to Sept. 22, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 22, 1966 , and that death occurred at 630 PM , from causes and on the date stated above.			
22a. SIGNATURE Francis C. Johnson M.D.		22b. DATE SIGNED Sept. 23 1966	
22c. PHYSICIAN'S NAME (Type) F. C. Johnson, M. D.		22d. ADDRESS h Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-26-66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Mt. Ranier ADDRESS Md.		25a. REC'D BY REGISTRAR SEP 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Valley's Funeral Home, 3200 Rhode Island Ave./	

15888

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

18881

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #26 Film #G300 9/19/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12862

12857

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. M.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>			d. STREET ADDRESS <u>Route 2, Box 167 1A</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Bryan</u> Last <u>BETTENDORF</u>			4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>19 66</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>21 Aug 1957</u>		9. AGE (In years last birthday) <u>9</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas City, Mo.</u>	
13. FATHER'S NAME <u>William BETTENDORF</u>			14. MOTHER'S MAIDEN NAME <u>Alice Jeanne BRYAN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William BETTENDORF, Hollywood, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Herbicide poisoning & infection</u> DUE TO (b) <u>Trauma</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>BOY RAN INTO STREET AND WAS STRUCK BY AUTOMOBILE</u>			
20c. TIME OF INJURY Month, Day, Year <u>4:30 p.m. 5 Sep 19 66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hollywood</u> <u>St. M.</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Sept 10, 1966</u>	
EXAMINER'S NAME (Type) <u>1818 Fern Rd S.W. D.C. 2001</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-12-66</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Garden Cem.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Kansas City, Kansas</u>		24. FUNERAL DIRECTOR <u>R.A. Pumpfrey, 7557 Wisconsin Ave., Bethesda, Md.</u>			
25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15225

15225

15225-15226 Memorial University of Newfoundland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their office remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional Manor Sanitarium</u>					d. STREET ADDRESS <u>4434 McArthur Boulevard</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Birdie</u> Middle <u>D</u> Last <u>Birch</u>					4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1966</u>														
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Montgomery</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>James Cox</u>					14. MOTHER'S MAIDEN NAME <u>Louise Wheeler</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>579-60-5500</u>					17. INFORMANT <u>Marie H. Cotton</u>					Address <u>4418 McArthur Blvd. Washington D.C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease</u> (c) <u>Generalized arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Small hours</u> <u>15 yrs</u> <u>15 yrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>present</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>16 Aug</u> 19 <u>66</u> , and that death occurred at <u>5:45 P</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Charles E. Keegan Jr.</u>										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>14 Sept 66</u>				
22c. PHYSICIAN'S NAME (Type) <u>CHARLES E. KEEGAN JR. MD</u>										22d. ADDRESS <u>3752 BENTON ST NW Wash DC</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>SEP. 17, 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>					23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u>				
24. FUNERAL DIRECTOR <u>Robert A. Dwyer</u>										25a. REC'D BY REGISTRAR <u>Home Wash DC</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marylander Rest Home		d. STREET ADDRESS 827 Whittier Place N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Martha R. Black		4. DATE OF DEATH Month Day Year Sept. 26 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/1884
9. AGE (In years last birthday) 82 yrs.		10. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Roberts		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-44-2890	
17. INFORMANT Martha J. Brosnan		Address 11609 Hitching Post Lane Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Paralysis agitans DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 15 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/22 , 19 56 to 9/26 , 19 66 , that (I) last saw the deceased alive on 9/23 , 19 66 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 9/26/66	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS 26618 Ridge Road, Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF September 28, 1966	
23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION (City, town or county) (State) Martinsburg, West Virginia	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25. REC'D BY REGISTRAR SEP 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12555

12555

Montgomery

Georgetown, Maryland

Harlingen, Texas

Fort

Black

Seneca White

Washington

Registered Nurse

Virginia

James Roberts

Harry Brown

no

218-22890

218-22890
Martha J. Brown
Rockville, Maryland

1100 Ritchie Road

James H. Kerr, M.D.

2018 W. 10th St., Washington, D.C.

British

September 20, 1960

1251 Rockville Pike

Washington, D.C.

Rockville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle ALAN Last BLAND, Jr.		4. DATE OF DEATH Month SEPTEMBER Day 18 Year 1966	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 AUG 1966
9. AGE (In years lost birthday) yrs. -		10. IF UNDER 1 YEAR Months 1 Days 5 Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL ALAN BLAND		14. MOTHER'S MAIDEN NAME MAY VIRGINIA TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA	
17. INFORMANT MICHAEL ALAN BLAND		Address 10819 BOSWELL LANE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PSEUDOMEMBRANOUS COLITIS, ASSOCIATED WITH PERITONITIS 5733 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 30 AUG , 1966, to 18 SEP , 1966, that (I) (we) last saw the deceased alive on 18 SEP , 1966, and that death occurred at 5:00 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>J. J. Tomasovic</i> M.D.		22b. DATE SIGNED 18 SEP 66	
22c. PHYSICIAN'S NAME (Type) J. TOMASOVIC, CAPT MC USAF		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-21-66	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN, INC.	23d. LOCATION (City or Town) _____ (County) _____ (State) _____ ROCKVILLE MONTGOMERY MD
24. FUNERAL DIRECTOR R.A. PUMPHREY		25a. REC'D BY REGISTRAR SEP 22 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified and Will Approve

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b Chevy Chase					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Montgomery b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5480 Wisconsin Ave. Apt. 727 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Edgar Middle Orville Last Blewett					4. DATE OF DEATH Month September Day 14 Year 1966						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/10		9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D.C. Government Inspector					10b. KIND OF BUSINESS OR INDUSTRY Inspector		11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Sanitation Engineer Walter Blewett					14. MOTHER'S MAIDEN NAME Clara Lucas						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 567-20-4035		17. INFORMANT Violet B. Blewett		Address 5480 Wisconsin Ave. Chevy Chase, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 42801 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH Immediate 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7-7-1954, to 7-25-1966, that (I) (we) last saw the deceased alive on 7-25-1966, and that death occurred at 4 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Louis Ross					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-14-66				
22c. PHYSICIAN'S NAME (Type) Louis Ross					22d. ADDRESS 1712 Eye St. N.W. Wash., D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/19/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Ft. Myer, Va.					
24. FUNERAL DIRECTOR The S.H. Hines Company					ADDRESS 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR SEP 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

13881

13882

ORIGINAL FILED IN 13881

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter with multiple paragraphs of text that is mostly illegible due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12867

CERTIFICATE OF DEATH

12862

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. d. STREET ADDRESS 902 Newhall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie no middle name Block First Middle Last		4. DATE OF DEATH Sept 21 19 66 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/1892
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of business	11. BIRTHPLACE (County & State, or foreign country) New York City, N. Y.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Greenblatt	
14. MOTHER'S MAIDEN NAME Fannie ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 044-05 9008-D		17. INFORMANT Howard Block Address 902 Newhall St. S.S.M.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Fibrosarcoma of neck DUE TO (c) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of uterus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 to Sept. 21, 1966 , that (I) was lost saw the deceased alive on 9/21 19 66 , and that death occurred on 11:35 PM , from causes on and on the date stated above.			
22a. SIGNATURE Norman H. Rubenstein M.D.		22b. DATE SIGNED 9/21/66	
22c. PHYSICIAN'S NAME (Type) Dr. Norman Rubenstein		22d. ADDRESS 6480 New Hampshire Ave., Tak. Pk., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/25/66	23c. NAME OF CEMETERY OR CREMATORY Waterbury Hebrew Cemetery	23d. LOCATION (City or Town) (County) (State) Waterbury, Connecticut
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR SEP 26 1966	
ADDRESS 3501-14th St. NW, Wash. DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

158851

158851

... ..

... ..

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

31 M
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12866											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY in 1b <u>1/2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>328 16th ST. S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>County Incinerator</u>						d. STREET ADDRESS <u>Washington</u>					
3. NAME OF DECEASED (Type or print) <u>John</u>			First Middle Last			4. DATE OF DEATH <u>Bolton</u>			Month Day Year <u>Sept 12 1966</u>		
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-1936</u>		9. AGE (in years last birthday) <u>30 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>United Disposal Co.</u>				11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cleo Bolton</u>				14. MOTHER'S MAIDEN NAME <u>Martha</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>257-56-5920</u>				17. INFORMANT <u>DeLores Bolton</u> ^{Wife} Address <u>328-16th Street S.E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest.</u> 9118 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Trauma from Pressure in Incinerator Truck. Sudden.</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Caught Head + shoulder in gate of incinerator Truck.</u>							
20c. TIME OF INJURY Month, Day, Year <u>9/12 1966</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rockville Incinerator</u>		20f. (City or town) (County) (State) <u>Rockville Mont. Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/12/66</u>		
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>John T. Rhines Co.,</u>						ADDRESS <u>3015 12th St., NE</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE						SEP 16 1966					

1520



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lewis Drive</u>				d. STREET ADDRESS <u>Mt. Airy</u>	
3. NAME OF DECEASED (Type or print) <u>Lee Roy Bosley</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/90</u>	9. AGE (in years last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Montgomery County, Md.</u>	
13. FATHER'S NAME <u>Thomas Bosley</u>		14. MOTHER'S MAIDEN NAME <u>Annie L. Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-1001</u>		17. INFORMANT <u>Mrs. Shirley Melvin, Damascus, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO (b) <u>Gunshot wound of head</u> DUE TO (c) <u>Self inflicted</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Shot self in head above and in front of right ear with revolver. Bullet lodged left sup. occ. region.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1:50</u> p.m. <u>9/10</u> 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
				20f. (City or town) (County) (State) <u>Damascus, Mont., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John S. Rogers</u>		EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		22. DATE SIGNED <u>September 10, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Christian</u>	
				23d. LOCATION (City, town or county) (State) <u>Hyattstown, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13864

19-23

RECEIVED
JAN 20 1964
U.S. DEPARTMENT OF
HEALTH, EDUCATION &
WELFARE
OFFICE OF THE
ASSISTANT SECRETARY
FOR PUBLIC HEALTH
DIVISION OF
COMMUNITY & PUBLIC
AFFAIRS

[Handwritten signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> d. STREET ADDRESS <u>505 Chillum Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Earl Clarence Bowers</u>			4. DATE OF DEATH <u>September 19</u> Month <u>19</u> Day <u>66</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1892</u>	9. AGE (in years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Beaver Falls, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Louis Bowers</u>			14. MOTHER'S MAIDEN NAME <u>Amelia Schramm</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>193-05-9225</u>			17. INFORMANT <u>Mrs. Dorothy Bell</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure secondary to</u> DUE TO (b) <u>anoxia due to</u> DUE TO (c) <u>aspiration of gastric contents</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased vomited and aspirated gastric contents</u>						
20c. TIME OF INJURY Month, Day, Year <u>9-19-66</u> Hour a.m. <u>9:30</u> p.m. <u> </u>			20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apt. Parking Lot</u>		20f. (City or town) <u>Hyattsville</u> (County) <u>P.G.</u> (State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden Reap</u>			EXAMINER'S NAME (Type) <u>Belden Reap</u>			22. DATE SIGNED <u>9-21-1966</u>		23. LOCATION (City, town or county) <u>Prince Georges Co., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Prince Georges Co., Md.</u>		
24. FUNERAL DIRECTOR <u>John B. Thomas</u>			24a. ADDRESS <u>8434 Georgia Avenue</u>			24b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>		24c. DATE <u>SEP 27 1966</u>	
24d. <u>Warner E. Pumphrey, Inc.</u>			24e. <u>Silver Spring, Md.</u>						

13805

13805

13805

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "United States" and "Department" are faintly visible.]

9-21-1964

United States Department of State

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. LENGTH OF STAY IN 1b <u>3 years</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Lida L. Bradford</u>					4. DATE OF DEATH <u>September 14</u> 19 <u>66</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scranton, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <u>James Leyshon</u>					14. MOTHER'S MAIDEN NAME <u>Susan Davis</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>578-07-2930-Webster C. Leyshon</u>					17. INFORMANT <u>10414 Huntley Avenue Silver Spring, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), end (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Uremia</u> 7500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Kidney Failure</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10, 1966</u> to <u>Sept 14, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 10, 1966</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.										22b. DATE SIGNED				
22a. SIGNATURE <u>Edward J. Richards</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>					22d. ADDRESS <u>10110 Ga. Avenue, Silver Spring, Maryland</u>					22b. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Sep. 17, 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>				
23d. LOCATION (City, town or county) <u>Colesville, Maryland</u>					23e. REC'D BY REGISTRAR <u>SEP 19 1966</u>					23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

1525

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14311

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Wash D.C.</u> COUNTY <u>Wash. D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>3811-Military Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Percy Cecil Brady</u>		4. DATE OF DEATH <u>Sept 30 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1892</u>
9. AGE (in years last birthday) <u>74</u> yrs.		10. FUND 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Henry Brady</u>		14. MOTHER'S MAIDEN NAME <u>Mary Amanda Brady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John Brady Silver Spring Md</u>	
17. INFORMANT <u>John Brady Silver Spring Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 1533 CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> (c) <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7:55 P 9-29, 1966</u> to <u>7:45 A 9-30, 1966</u> ; that (I) (we) last saw the deceased alive on <u>9-30 1966</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Blaine H. Eig</u>		22b. DATE SIGNED <u>9-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Blaine H. Eig</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10-3-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount. Olivet</u>	23d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR <u>Thomas B. Harlow</u>		25a. REC'D BY REGISTRAR <u>4448 Olive Ave NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1966</u>	

11551

87231



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonville</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>SUBURBAN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Boy</u> First <u>BRIGHT</u> Middle <u>BRIGHT</u> Last		4. DATE OF DEATH <u>Sept 22</u> Month <u>19</u> Day <u>66</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 66</u>
9. AGE (In years lost birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>66</u> Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>BETHESDA, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Bright</u>		14. MOTHER'S MAIDEN NAME <u>SHELIA BRIGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Matthew</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Sept 22, 1966</u> , and that death occurred at <u>7:00</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>J Thornton Boswell M.D.</u>		22b. DATE SIGNED <u>9.25.66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J Thornton Boswell M.D.</u>		22d. ADDRESS <u>Suburban Hospital, Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonville, Md</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

18203

RECORDS OF DEATH

18203

Thornton Bonnelly H.B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12874

12868

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Gate</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll Hall Nursing Home</i>		d. STREET ADDRESS <i>5010 Newport Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>GEORGIANA</i> Middle <i>B.</i> Last <i>BROCK</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>20</i> Year <i>1966</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 3, 1867</i>
9. AGE (In years last birthday) <i>98</i> yrs.	IF UNDER 1 YEAR Months <i>9</i> Days <i>17</i>		IF UNDER 24 HRS. Hours <i>17</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>William Harrison Brown</i>		14. MOTHER'S MAIDEN NAME <i>Ann Jane Glenn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>236-14-4566</i>	
17. INFORMANT <i>Daughter Evelyn B. McClure</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>senile heart disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>63</i> , to <i>Sept</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept 20</i> , 19 <i>66</i> , and that death occurred at <i>7 P</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Marvin Wadler</i>		22b. DATE SIGNED <i>9/20/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER</i>		22d. ADDRESS <i>8218 Wise. Av. Beth., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit 9-22-66</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Bluemont Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Grafton, West Virginia</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		25a. REC'D BY REGISTRAR <i>SEP 22 1966</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12875 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4005 Beverly Road</u>		12869 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>4005 Beverly Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Willse</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1908</u>
9. AGE (In years last birthday) <u>58 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. of Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Westfield, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hudson R. Willse</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-0909</u>	
17. INFORMANT <u>C. Willman Brown</u>		Address <u>4005 Beverly Road Rockville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20, 1966</u> to <u>Sept. 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 30, 1966</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederick Mooman</u> M.D.		22b. DATE SIGNED <u>Sept. 30, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick Mooman, M.D.</u>		22d. ADDRESS <u>4000 Beverly Rd., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Norfolk, Virginia</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

15204

15204



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12870

12876

CERTIFICATE OF DEATH

Classed as Coronary

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood c. LENGTH OF STAY IN 1b 15-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6412 Highland Drive				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood d. STREET ADDRESS 6412 Highland Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marshall Earl Brushhart				4. DATE OF DEATH Month Day Year Sept. 11, 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-1896	
9. AGE (In years lost birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		11. BIRTHPLACE (County & State, or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Brushhart				14. MOTHER'S MAIDEN NAME Josephine Morris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918		16. SOCIAL SECURITY NO. 579-52-4399		17. INFORMANT See Item No. 2. Mrs. Ruthanna Maxwell Brushhart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) Massive Coronary Occlusion DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }						INTERVAL BETWEEN ONSET AND DEATH instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3 Previous coronary thromboses -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 9-11 , 19 66 , that (I) (we) last saw the deceased alive on 9-3 19 66 , and that death occurred at 4:15 P.M. from causes and on the date stated above.							
22a. SIGNATURE Geo. R. Huffman				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) GEORGE R. HUFFMAN				22d. ADDRESS 1912 - R St. Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-14-1966		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR DATE SEP 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

15830

15830

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12877					12871				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Montgomery		Wheaton			Maryland		Montgomery		
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
		2610 Kensington Blvd.			Wheaton		2610 Kensington Blvd.		
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
MARK		ETTA		BURGESS		SEPT. 26		19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F	Negro	WIDOWED	DIVORCED	Mar. 7, 1877	89 yrs.	Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None				Maryland		U.S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Cato Poole				Tamar Wheeler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address			
		215-50-6396		Mrs. Mary Murphy		Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE 334 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSION, HEART DISEASE DUE TO (c) ARTERIO SCLEROSIS								INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CANCER FACE								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 6, 1959, to Sept 26, 1966, that (I) (we) last saw the deceased alive on Sept 16, 1966, and that death occurred at 2:54 PM, from the causes and on the date stated above.									
22a. SIGNATURE				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		9/30/66		Lincoln Memorial		Suitland, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert L. Snowden Rockville, Md.				DATE SEP 28 1966		f Charles Judge			

15851

EXHIBIT IN CASE

15851

NOT RECORDED
JAN 19 1964



U.S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12878

12872

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>10820 Georgia Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>A</u> Last <u>Burton</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/9/1896</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Police Officer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Walter T Burton</u>				14. MOTHER'S MAIDEN NAME <u>Edna Atkinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Navy</u>				16. SOCIAL SECURITY NO. <u>578-44-033</u>			
17. INFORMANT <u>10415 Edna H. Kensington</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiac vascular disease</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1960</u> , 19 <u>60</u> , to <u>9/18/1966</u> , that (I) (we) last saw the deceased alive on <u>9/18</u> 19 <u>66</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John B. Unkhou</u>				22b. DATE SIGNED <u>9/18/66</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UNKHOU</u>	
22d. ADDRESS <u>8805 Conn. Ave. Chevy Chase 15 Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/21/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>HYSONG'S FUNERAL HOME</u> ADDRESS <u>WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1583

552

005115/16

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12879

12873

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. STREET ADDRESS 6430 8th Street N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Albert Henry BUSCHLING		4. DATE OF DEATH Month Day Year 9 13 1966	
5. SEX m	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9-2-94
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Pressman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME William		14. MOTHER'S MAIDEN NAME Jo Anna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Patient's Chart.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 days unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) Arteriosclerotic cardio-vascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 8, 1966 , to Sept. 13, 1966 , that (I) (we) last saw the deceased alive on Sept 13, 1966 , and that death occurred at 5:30 p.m. , from causes and on the date stated above.			
22a. SIGNATURE Eino Magi		22b. DATE SIGNED Sept. 13, 1966	
22c. PHYSICIAN'S NAME (Type) EINO MAGI		22d. ADDRESS 831 Univ. Blvd. E., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 16, 1966	23c. NAME OF CEMETERY OR CREMATORY George Washington	23d. LOCATION (City or Town) (County) (State) Adelphi Md.
24. FUNERAL DIRECTOR Glenn Walters, 254 Carver St NW Wash. D.C.		25a. REC'D BY REGISTRAR SEP 16 1966	
		25b. REGISTRAR'S SIGNATURE John J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15873

DEPARTMENT OF STATE

15873

Washington, D.C. 20520
Mr. [Name] [Address]
[City] [State] [Zip]
[Country]

Dear Sir:
[Faint body text of the letter]

Sincerely,
[Signature]
[Name]
[Title]
[Department of State]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12880

CERTIFICATE OF DEATH

12874

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 5717 First Street, South	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Murray CAHILL		4. DATE OF DEATH Month Day Year September 23 1966	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1924
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Bronx, New York
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown Louis MURRAY	
14. MOTHER'S MAIDEN NAME Evelyn Heelan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 100-18-4121		17. INFORMANT CDR John CAHILL Address 5717 First Street, South, Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Left Breast with widespread Metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XX (this hospital) attended the deceased from 19 Sept. , 1966, to 23 Sept , 1966, that XX (we) last saw the deceased alive on 23 Sept , 1966, and that death occurred at 2:20PM , from causes and on the date stated above.			
22a. SIGNATURE Stanley S. Weglarz		22b. DATE SIGNED 24 Sept 1966	
22c. PHYSICIAN'S NAME (Type) Stanley S. WEGLARZ M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-27-66	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Murphy Funeral Home ADDRESS 3524 Columbia Pike, Arlington, Va		25a. REC'D BY REGISTRAR DATE SEP 27 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

15834

RECORD OF DEATH

15834

Name of Deceased		Date of Death	
John Doe		1912	
Age		Sex	
50		Male	
Place of Birth		Cause of Death	
New York		Heart Disease	
Occupation		Residence	
Teacher		123 Main St.	
Married		Buried	
Yes		Yes	
Spouse Name		Funeral Home	
Jane Doe		Smith & Sons	
Date of Burial		Place of Burial	
1912		Cemetery	
Buried		Remarks	
Yes		None	

15834

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12881

CERTIFICATE OF DEATH

12875

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Lee	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bokeelia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ford Middle Alberto Last CAMPBELL		4. DATE OF DEATH Month Sept Day 1 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 JULY 1910
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		12. KIND OF BUSINESS OR INDUSTRY N/A	
13. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Robert Campbell		16. MOTHER'S MAIDEN NAME Permelia Smith	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES		18. SOCIAL SECURITY NO. 578-22-8492	
19. INFORMANT Mrs. Ruth A. Campbell		20. 324th Independence Ave Washington, D.C.	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse hemorrhage right lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Bronchogenic Carcinoma (Epidermoid) DUE TO (c) 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NA		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) NA	
23. TIME OF INJURY Month, Day, Year Hour a.m. NA p.m. 19		24. INJURY OCCURRED While <input type="checkbox"/> NA While <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NA		26. (City or town) (County) (State) NA	
27. I certify that XX (this hospital) attended the deceased from 1 August, 1966 , to 1 Sept., 1966 that (X) (we) last saw the deceased alive on 1 September 1966 , and that death occurred at 12:30 PM from causes and on the date stated above.			
28. SIGNATURE Robert J. Kinney		29. DATE SIGNED 3 September 1966	
30. PHYSICIAN'S NAME (Type) Robert J. Kinney LCDR MC USN		31. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
32. BURIAL, CREMATION, or other disposition (Specify) Burial		33. DATE THEREOF 9-6-1966	
34. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		35. LOCATION (City or Town) (County) (State) Arlington, Va.	
36. FUNERAL DIRECTOR Mattingly Funeral Home		37. ADDRESS 131 11th Street, S.E., Washington, D.C.	
38. REC'D BY REGISTRAR SEP 8 1966		39. REGISTRAR'S SIGNATURE Charles Judge	

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

15252

12882

CERTIFICATE OF DEATH

12876

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium Ind Hospital</u>				d. STREET ADDRESS <u>7500 Maple Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Glenn</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4-9-03</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S.D.A. Penmanship</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Chloe Roberts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Washington San. + Hospital Records</u> Address <u>Takoma Park Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute upper GI Hemorrhage</u> DUE TO <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>massive myocardial infarction</u> DUE TO <u></u> (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 dys</u> <u>several yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u> <u>obesity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>9-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-13</u> , 19 <u>66</u> , and that death occurred on <u>9-13</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>R.H. Sandstrom</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R.H. Sandstrom MD</u>				22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		23b. DATE THEREOF <u>Sept 17-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Waters</u>				25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15236

EDUCATION DEPARTMENT

15236

THE UNIVERSITY OF CHICAGO PRESS
54 EAST LAKE STREET, CHICAGO, ILL. 60601
U.S. GOVERNMENT PRINTING OFFICE: 1963 O 550-000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12883

12877

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Rt. 1, Box 389	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Rachel Middle Elizabeth Last Carroll		4. DATE OF DEATH Month 9 Day 29 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) charwoman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Boyd		14. MOTHER'S MAIDEN NAME Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital admission record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive Heart Failure DUE TO Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days YTS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/22/66 , 19 66 , that (I) (we) last saw the deceased alive on 9/29 , 19 66 , and that death occurred at 2:10 PM , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 9-29-66	
22c. PHYSICIAN'S NAME (Type) Jack Schwabacher, M.D.		22d. ADDRESS Sandy Spring, Gaithersburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/3/66	
23c. NAME OF CEMETERY OR CREMATORY Brooke Grove		23d. LOCATION (City or Town) (County) (State) Laytonsville Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR DATE OCT 6 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15251

8251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10P

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12884					12878					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Montgomery</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b						
<u>Laurel Park</u>				<u>3 days</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Washington Sanand. Hospital</u>					<u>Chillum</u>				<u>1623</u>	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last <u>Antorio NMN Catena</u>					Month Day Year <u>9 - 18 19 66</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
<u>male</u>		<u>white</u>				<u>6-22-01</u>		<u>65</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
<u>Foreman Retired</u>			<u>Capitol transit</u>			<u>Italy</u>			<u>USA</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<u>Giuseppe Catena</u>					<u>Rosa Brienza</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address					
<u>NO</u>			<u>579-01-9409</u>		<u>Hospital Records</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>									<u>2 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>Diabetes mellitus</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1966</u> to <u>Sept 18, 1966</u> , that (we) last saw the deceased alive on <u>Sept 17, 1966</u> , and that death occurred at <u>3:45 AM</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>E. P. Ingel</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/18/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>E P INGEL</u>					22d. ADDRESS <u>1222 MONROE ST N.E WASH DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>BURIAL</u>			<u>9-22-66</u>		<u>FT. LINCOLN</u>			<u>BLADENSBURG MD</u>		
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS & CO. RIVERDALE MD</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 21 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

45251

RECORDS OF THE

43881



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12885

CERTIFICATE OF DEATH

12879

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pennsieglass</u>		c. LENGTH OF STAY IN 1b <u>4 Mos. 23 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Huntington Gardens Nursing Home</u>		d. STREET ADDRESS <u>2019- REEDIE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>(NM)</u> Last <u>CHAKERES</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Panayioti Manolakis</u>		14. MOTHER'S MAIDEN NAME <u>Panayiota</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>579-44-4991</u>	
17. INFORMANT <u>Mrs. Pauline Anthos</u>		Address <u>4406 Old Capitol Trail Wilmington, Delaware</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST</u> DUE TO (b) <u>170X</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUL</u> , 19 <u>66</u> , to <u>Sept</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1 Sept 19 66</u> and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Gooch</u>		22b. DATE SIGNED <u>1 Sept 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOOCH MD</u>		22d. ADDRESS <u>2340 GLENMONT CIR WHEATON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 6, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15250

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12886

CERTIFICATE OF DEATH

12880

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>18 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>H.</u> Last <u>CLAIBORNE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CPA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stacy Malone</u>	9. AGE (In years last birthday) yrs. <u>70</u>
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HOGAN CLAIBORNE</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BELLE ONEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>LILLIAN N. CLAIBORNE - See Item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <u>Brain Tumors</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Osteoporosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1965</u> , to <u>Sept 20, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 20, 1966</u> and that death occurred at <u>4:55 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>9/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>		22d. ADDRESS <u>10620 Georgia Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-22-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Arlington Va</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash. DC.		DATE <u>SEP 26 1966</u>	

15200

STATE OF NEW YORK

15200

Blank document with faint horizontal lines and two punch holes on the right side.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>55 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>606 Sligo Avenue</u>		d. STREET ADDRESS <u>606 Sligo Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1886</u>
9. AGE (in years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bailey R. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hardesty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Grace Clark</u>		Address <u>606 Sligo Avenue Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1956</u> , to <u>Sept 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 31, 1966</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Wardrop, M.D.</u>		22b. DATE SIGNED <u>Sept 2 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. B. Wardrop, M.D.</u>		22d. ADDRESS <u>800 Pershing Drive, S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 6, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

15000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12888

CERTIFICATE OF DEATH

12882

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>9904 PORTLAND RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>LEOYD</u> Middle <u>MASON</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-92</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal screens</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Seymour Clark</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mae Terrence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>217-32-1160</u>	
17. INFORMANT <u>Flossie B. Clark</u>		Address <u>9904 Portland Road Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO <u> </u> (b) <u>Benign Bronchogenic Carcinoma & Metastases</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>6 mo's.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis and Emphysema; Hypertensive Cardiovascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>Sept 17</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>Sept 17</u> , 19 <u>66</u> , and that death occurred at <u>9:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u> M.D.		22b. DATE SIGNED <u>Sept 17, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER, M.D.</u>		22d. ADDRESS <u>10620 GEORGIA AVE, SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 21, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15885

10420 10 11200 10

15885

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

10420 10 11200 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared through Medical Examiner, Dr. Below Reap

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONT GOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONT GOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRLAND NURSING HOME		d. STREET ADDRESS 8314 CAREY LANE	
3. NAME OF DECEASED (Type or print) JUDSON W. CLEMENTS		4. DATE OF DEATH 9 2 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSP. PENNA R.R.		11. BIRTHPLACE (County & State, or foreign country) ROME GEORGIA	
13. FATHER'S NAME CISERO CLEMENTS		14. MOTHER'S MAIDEN NAME SARAH WARDLAW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 716 16 7573A	
17. INFORMANT ROSE LATVA RN.		Address 2101 FAIRLAND RD. SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 147X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypopharyngeal Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH immediate 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 1966, to Sept. , 1966, that (I) (we) last saw the deceased alive on Aug 31 , 1966, and that death occurred at 9 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Allen S. Gardner		22b. DATE SIGNED Sept 2, 1966	
22c. PHYSICIAN'S NAME (Type) Allen S. Gardner		22d. ADDRESS 1807 Eldon Lane Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept 7-66	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town or county) (State) Pennsylvania	
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR SEP 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS	

15284

15284

MONT GAREY

MONT GAREY

SILVER SPRING

SILVER SPRING

FAIRLAND NURSING HOME 8314 CAREY LANE

Judson

CLEMENTS

W.

2

MALE WHITE

6-28-83

83

INSP. PENNA RR

ROME, GEORGIA USA

CISERO CLEMENTS

SARAH WARDLAW

JUL 16 1984

ROSE LANE RD

201 PARKING RD
SILVER SPRING MD

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

M

12890

12884

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>13 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>9606 Falls Rd</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>S</u> Middle <u>Coakley</u> Last				4. DATE OF DEATH <u>Sept</u> Month <u>22</u> Day <u>19</u> Year <u>66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/25/10</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRW</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ghent Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William S. Coakley</u>			
14. MOTHER'S MAIDEN NAME <u>Mary August</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>091-20-8096</u>				17. INFORMANT <u>Mrs. Adele C. Coakley-Wife-9606 Falls Rd.</u> Address <u>Potomac, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>66</u> , to <u>9-22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-24</u> , 19 <u>66</u> , and that death occurred at <u>1:45</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>William H. Killay</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>SEP 22 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. Killay, M.D.</u>				22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. RECD BY REGISTRAR <u>SEP 26 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and for any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G381 10/14/66 pc

12881

CERTIFICATE OF DEATH

12885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>2412 SEMINARY ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>M</u> Middle <u>COLLINS</u> Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK-TYPIST</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>			4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1966</u> 8. DATE OF BIRTH <u>7/2/09</u> 9. AGE (In years last birthday) <u>57</u> yrs. 11. BIRTH PLACE (County & State, or foreign country) <u>WASHINGTON DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>JOHN MCCARTHY</u> 14. MOTHER'S MAIDEN NAME <u>BRIDGET T. REED</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>MISS TERESA COLLINS</u> Address <u>SAME AS #2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with Metastases</u> <u>1538</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>26 Sept</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>25 Sept</u> , 19 <u>66</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>William D. Aud</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>William D. Aud, M.D.</u>			22b. DATE SIGNED <u>9/26/66</u> 22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>			
24. FUNERAL DIRECTOR <u>Francis J. Collins</u> ADDRESS <u>Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			
23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>							

REGS I

2221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12892

CERTIFICATE OF DEATH

12886

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital			d. STREET ADDRESS 4925 E. Capitol St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Connor			4. DATE OF DEATH Month September Day 18, Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/18/10		9. AGE (In years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Peter J. Connor			14. MOTHER'S MAIDEN NAME Bridgett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Right Kidney DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 8/8/66 , 19 66 , to 9/17/66 , 19 66 , that (I) (we) last saw the deceased alive on 9/17/66 , 19 66 , and that death occurred at 2:30 P M, from causes and on the date stated above.					
22a. SIGNATURE Timothy James Tehan M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/19/66	
22c. PHYSICIAN'S NAME (Type) Timothy James Tehan, M.D.		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Ceme.	
23d. LOCATION (City or Town) Washington, D.C.		(County)		(State)	
24. FUNERAL DIRECTOR Howard L. Stewart		ADDRESS N. 4000 4th Avenue		25a. REC'D BY REGISTRAR SEP 23 1966	
25b. REGISTRAR'S SIGNATURE Charles J. Jones					

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

13226

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp</u>		d. STREET ADDRESS <u>11727 College View Dr</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mae Elizabeth Conrad</u>		4. DATE OF DEATH Month Day Year <u>Sept 9 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Co. ca</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1909</u>
9. AGE (In years last birthday) <u>57 yrs.</u>		10. IF FUNERAL 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Fayette City, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Matthew Posey</u>		14. MOTHER'S MAIDEN NAME <u>Rose Posey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes 577-05-7769</u>	
17. INFORMANT <u>HUSBAND Regis Conrad</u>		Address <u>11727 College View Dr JAMAICA S.S., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac Arrest</u> 490X DUE TO (b) <u>Lobar pneumonia</u> DUE TO (c) <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John H. Rogers</u>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John H. Rogers</u>		22. DATE SIGNED <u>Sept 9, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>	
ADDRESS <u>8434 Ga. Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1588

10 13

[Faint, mostly illegible handwriting covering the main body of the page. Some words like "The", "and", "of", "in" are visible.]

[Faint text at the bottom of the page, possibly a signature or footer. Some words like "The", "and", "of", "in" are visible.]

FOR STATE HEALTH DEPT.

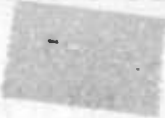
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) a. STATE <u>M.D.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in lb <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plainsboro</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>		d. STREET ADDRESS <u>54 Edgemoore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Douglas M. Cormack Jr.</u>		4. DATE OF DEATH <u>Sept 10 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 1944</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sailor</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DOUGLAS M. CORMACK</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> Active Duty		16. INFORMANT <u>DOUGLAS M. CORMACK SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Transection Aorta</u> DUE TO (c) <u>Automobile Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>His car collided with another car.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:22 p.m. Sept 9, 1966</u>	20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers M.D.</u>		22. DATE SIGNED <u>Sept. 10, 1966</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>9/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BRAINARD</u>
24. FUNERAL DIRECTOR <u>W.W. Chamber's & Co.</u>		25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>	
ADDRESS <u>1400 Chapin St. NW Wash, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



15884

15884



Autobio 10/10/10

SEP 1 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12895

12889

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>28 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Rt 109</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie Margaret Crampton</u>		4. DATE OF DEATH <u>Sept - 15</u> 19 <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/06</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James H. Onley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Don Donald C. Crampton</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma, diffuse, pulmonary bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>143X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-1-66</u> , 19 <u>66</u> , to <u>9-15, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> 19 <u>66</u> , and that death occurred at <u>1145</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Donald L Bucy</u>		22b. DATE SIGNED <u>9-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald L Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Epizah Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Foolesville Montg Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>	
ADDRESS <u>Rockville Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1329A

RECORD OF DEATH

1329B

1329C

1329D

1329E

1329F

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12896

12890

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4904-Chapin Ave. S.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>L.</u> Last <u>Creamer</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1966</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-88</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Harben C. Creamer</u>			14. MOTHER'S MAIDEN NAME <u>Clara Hooper</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>579-01-5539</u>		17. INFORMANT <u>Hrita Creamer</u> Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> DUE TO (b) <u>coronary occlusion</u> DUE TO (c) <u>arterio-sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>64</u> , to <u>September 16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>September 16</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph S. Norton</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9/17/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Joseph S. Norton</u>			22d. ADDRESS <u>7710 Dwight Dr. Washington D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-20-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City or Town) <u>Prince Georges Co. Md.</u>		(County)		(State)			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>			25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
5130 Wisc. Ave. N.W. Wash. D.C.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

18281

2251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN ID 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS 9505 Michael Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin Stanton Crisp, Jr.		4. DATE OF DEATH Month September Day 19 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 September 1934 32 yrs.
9. AGE (In years last birthday) 32		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Agent	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin S. Crisp, Sr.		14. MOTHER'S MARDEN NAME Anna Willis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-44-0141	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compression of the spinal cord at C2-3 DUE TO (c) Hodgkin's disease			INTERVAL BETWEEN ONSET AND DEATH 4 days 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that MD (this hospital) attended the deceased from Sept. 17 , 19 66 , to Sept. 19 , 19 66 , that (X) (we) last saw the deceased alive on Sept. 19 , 19 66 , and that death occurred at 10:45 , from the causes and on the date stated above.			
22a. SIGNATURE Herbert E. Kann, Jr., M.D.		22b. DATE SIGNED Sept. 20, 1966	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/23/66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) XXXX Prince Georges, Md.
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. Suitland, Md.		25a. REC'D BY REGISTRAR SEP 23 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

12891

MONROVIA

BARBUDA

The Clinical Center, Bethesda, Maryland, 20814

October 10, 1964

September 1964

U.S. Government

Special Agent

William A. Smith, Jr.

70-44-0141

Re: Laboratory report

Comparison of the spinal fluid at 02-3

Re: Patient's disease

Page IV

Page 19

The Clinical Center, National

Department of Health, Bethesda, Maryland

With reference to your letter of

September 10, 1964

and your letter of September 10, 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12898

12892

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 47-3 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fairland Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Dist. of Col. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4534 Reno Road, N.W. d. STREET ADDRESS 4534 Reno Road, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha S. Davis		4. DATE OF DEATH Month Day Year Sept 25 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1879
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 10 years 10 months 10 days 10 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — — — — —		10b. KIND OF BUSINESS OR INDUSTRY — — — — —	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Heulings Savage		14. MOTHER'S MAIDEN NAME Mary Nord	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — — — — —		16. SOCIAL SECURITY NO. 578-62-0532	
17. INFORMANT Miss Dorothy L. Orrison		Address See Item No. 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of Left Foot 4501 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 10 years 10 months 10 days 10 min.		INTERVAL BETWEEN ONSET AND DEATH 36 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to Sept 25, 1966 that (I) (we) last saw the deceased alive on Sept 23, 1966 , and that death occurred at 6:57 A.M. , from causes and on the date stated above.			
22. SIGNATURE Neil P. Campbell		22b. DATE SIGNED 9/25/66	
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell		22d. ADDRESS 1629 Columbia Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem		23d. LOCATION (City or Town) (County) (State) Arlington Va	
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc 5130 Wisconsin Ave. N.W. Wash. DC.		25a. REC'D BY REGISTRAR SEP 27 1966	
25b. REGISTRAR'S SIGNATURE John J. ...			

5251

2.295

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12899						12893					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Montgomery</i>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c. LENGTH OF STAY IN lb <i>21 Days</i>			d. STREET ADDRESS <i>13850 Travilah Road</i>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First <i>Harry</i> Middle <i>J</i> Last <i>Davis</i>						Month <i>Sept</i> Day <i>22</i> Year <i>1966</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-30-1891</i>		9. AGE (In years lost birthday) yrs. <i>75</i>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				13. FATHER'S NAME <i>John Davis</i>				14. MOTHER'S MAIDEN NAME <i>Annie Brown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-03-3764</i>				17. INFORMANT <i>5927 Address Hilltop Ave (Daughter) - Ann Corbett Baltimore Md -</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Failure</i>										<i>10 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Electrolyte Imbalance</i>										<i>10 days</i>	
(c) <i>Paralytic Ileus & Intestinal Obstruction</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe Gastrointestinal Obstruction</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> , 19 <i>66</i> , to <i>9-21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9-22-1966</i> , and that death occurred at <i>3:45 A.M.</i> from causes and on the date stated above.											
22a. SIGNATURE <i>William Henry Killog</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>9-26-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		23d. LOCATION (City or Town) (County) (State) <i>Beallsville, Md</i>			
24. FUNERAL DIRECTOR <i>F.C. Higinbotham, Ellicott City, Md</i>						25a. REC'D BY REGISTRAR DATE <i>SEP 26 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

15229

15229

15229

15229

15229

15229

15229

1 12900 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 12894

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton (Rural)</u> c. LENGTH OF STAY IN 1b <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2204 Parker Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton (Rural)</u> d. STREET ADDRESS <u>2204 Parker Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Theresa</u> Last <u>DeSarno</u>				4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1966</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 3, 1917</u>		9. AGE (In years last birthday) <u>49</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker Housewife Own Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Dominic Gallo</u>				14. MOTHER'S MAIDEN NAME <u>Palma Boise</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>2204 Parker Ave. Wheaton, Md.</u> <u>James U. DeSarno</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the nasopharynx & tonsil</u> DUE TO (b) <u>1992</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1992</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>2 years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 3, 1966</u> to <u>Sept 4, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 3, 1966</u> and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Blain H. Eig</u>				22b. DATE SIGNED <u>Sept 4, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Blain H. Eig</u>		22d. ADDRESS <u>2641 Columbia Rd. Silver Spring, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven XXXX cem.</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clark E. Warner</u> <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881

1881

STATE OF NEW YORK

IN SENATE

JANUARY 1881

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1880

ALBANY:

1881

W. H. BROWN,

PRINTED BY

THE STATE

OF NEW YORK

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

1881

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12895

FOR STATE HEALTH DEPT.

12901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6417 CAMROSE TERRACE				d. STREET ADDRESS 6417 CAMROSE TERRACE			
3. NAME OF DECEASED (Type or print) First Middle Last AGNES T. DEVEREAUX				4. DATE OF DEATH Month Day Year SEPT 25 19 66			
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-13-1898	
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 7 12		11. BIRTHPLACE (State or foreign country) NEWPORT, R.I.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) NEWPORT, R.I.	
13. FATHER'S NAME ANDREW J. KANE				14. MOTHER'S MAIDEN NAME Mary Ellen Murphy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT MRS. ROSEMARY CORBIN		Address 5530 Johnson Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 4201 DUE TO Cardio Vascular Disease (b) Cardio Vascular Disease DUE TO (c) Obesity							INTERVAL BETWEEN ONSET AND DEATH Sudden years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball		EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 9/25/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE SEP 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12902

12896

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE OHIO b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodacres		c. LENGTH OF STAY IN 1b 3 Mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5918 Harwick Road		d. STREET ADDRESS 1742 Radcliffe Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLA Middle M. Last DeWITT		4. DATE OF DEATH Month Sept. Day 18, Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1879
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months 9 Days 27 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR OCCUPATION Civil Govt. Montg. Co., Ohio	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles H. Gunter	
14. MOTHER'S MAIDEN NAME Harriet Pinkerton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 292-14-8229		17. INFORMANT Woodacres, Bethesda, Md. George M. Lohnes-Son-5918 Harwick Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency Acute DUE TO (b) Cardio-Vascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 			INTERVAL BETWEEN ONSET AND DEATH Sudden 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Bethesda, Md.	
22. DATE SIGNED Sept. 18, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	23b. DATE THEREOF 9/19/66	23c. NAME OF CEMETERY OR CREMATORY Germantown Cemetery	23d. LOCATION (City or Town) (County) (State) Germantown Ohio
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR SEP 20 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1880

1880

Barthel, Hinnerton

Charles H. Gunter

1881-14-0000

1881

George H. Gunter, Jr. (in-law)

Germanstown Cemetery, Germanstown, Ohio

Germanstown Cemetery, Germanstown, Ohio

Germanstown Cemetery, Germanstown, Ohio

Germanstown Cemetery, Germanstown, Ohio

12 1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12903

CERTIFICATE OF DEATH

12897

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Silver Spring Nursing Home		d. STREET ADDRESS 3006 Laurel Avenue	
3. NAME OF DECEASED (Type or print) First Stanley Middle A. Last Diana		4. DATE OF DEATH Month Sept. Day 18, Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1902
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. of Justice Ret. Asst. Dist. Comm. U.S. Government		11. BIRTHPLACE (County & State, or foreign country) New York	
13. FATHER'S NAME John Diana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no c		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Genevieve C. Diana Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH. 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 66 , to 9/18 , 19 66 , that (I) (we) last saw the deceased alive on 9/16 , 19 66 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE J. Leonard Ford		22b. DATE SIGNED 9/19/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/66	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City or Town) (County) (State) Brooklyn, N. Y.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12904

12896

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b ??	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4516 Gladwyne Street		e. STREET ADDRESS 4516 Gladwyne Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHRISTABEL Middle F. Last DODGE		4. DATE OF DEATH Month Sept. Day 21, Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1895
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months 8 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt - Retired		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (County & State, or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Benjamin Franklin	
14. MOTHER'S MAIDEN NAME Mary Dawtel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 495-30-8351		17. INFORMANT Son Herbert W. Dodge Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH few minutes sev. yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus since 1944			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/30, 1955 , to 9/21, 1966 , that (I) (we) last saw the deceased alive on 8/26 1966 and that death occurred at 11 A M, from causes and on the date stated above.			
22a. SIGNATURE Michel M. Healy M.D.		22b. DATE SIGNED 9-21-66	
22c. PHYSICIAN'S NAME (Type) MICHEL M. HEALY		22d. ADDRESS Washington Clinic Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/23/1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland P.G. Co. Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 26 1966	
		25b. REGISTRAR'S SIGNATURE Charles J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12504

RECORD OF DEATH

12504

ASIA CLAWING SERVICE

ASIA CLAWING SERVICE

68

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

70

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

U.S.

Illinois

U.S. Govt. Hospital

John Doe

John Doe

Same as item 1.

WILSON, J. W. (Sgt.)

100-30-1231

70

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

WILSON, J. W. (Sgt.)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12905

12899

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>5 hrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>10109 Greeley Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>May</u> Last <u>Donwart</u>				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/98</u> 95		9. AGE (In years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Michael H. Janbert</u>				14. MOTHER'S MAIDEN NAME <u>Lillie J. Wilhelm</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. James L. Rankin</u> Address <u>10109 Greeley Ave. S. S., Md.</u> <u>Daughter</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial disease</u> DUE TO (b) <u>Chronic congestive heart failure</u> DUE TO (c) <u>Generalized arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>6 yr.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u> EXAMINER'S NAME (Type) <u>1919 Seminary Rd., Silver Spring, Md.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>September 9, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Harrisburg Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Harrisburg, Pennsylvania</u>		
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>8434 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Maryland	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 12418 Seven Locks Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12418 Seven Locks Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma		4. DATE OF DEATH Month Sept. Day 29 Year 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 9, 1885	
9. AGE (in years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 20 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-12-5813	
17. INFORMANT Earl E. Dove- Son-		Address Rockville, Md. 4800 Oxbow Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension + obesity			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/2/66 , 19__, to 9/29/66 , 19__, that (I) (we) last saw the deceased alive on 9/21/66 , 19__, and that death occurred at 20M , from the causes and on the date stated above.			
22a. SIGNATURE Patrick Jameson		22b. DATE SIGNED 9/29/66	
22c. PHYSICIAN'S NAME (Type) Dr. Patrick Jameson, M.D.		22d. ADDRESS 11718 Georgia Avenue, Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/66	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR OCT 3 1966	
ADDRESS 1331 Rockville Pike Rockville, Maryland 20852		25b. REGISTRAR'S SIGNATURE Charles Judge	

13300

13300

Monetary

Monetary

Monetary

Rockville, Maryland

Rockville, Maryland

12-18 seven look road

12-18 seven look road

82

20

Sept.

Dove

12/1

Sam

1-30

31

August 3, 1957

X

Female white

U.S.A.

Virginia

Monetary

Rockville, Md.

512-15-5012 East E. Dove - 4800 Xbow Road

--- No

Caravan + 1000000

Hydrometer - 0.0001

12/10

12/10

12/10

Patent 1/10/58

12/10

Dr. Patrick Jameson, W.D. 11710 Georgia Avenue, Silver Spring, Md.

Rockville, Maryland

Virginia Secretary

10/1/58

Bureau

Tyson Hewitt 1571 Rockville Pike

Rockville, Maryland 20852

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12907
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
12901

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>New Jersey</i> b. COUNTY <i>Y. Orchard</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>25 Days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hosp. of Silver Spring</i>		d. STREET ADDRESS <i>1 S. Myrtle ST.</i>	
3. NAME OF DECEASED (Type or print) <i>Eleanor B. Dubinsky</i>		4. DATE OF DEATH Month <i>9</i> - Day <i>25</i> - Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-16-07</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- -</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frederick Meyerholz</i>		14. MOTHER'S MAIDEN NAME <i>Mary C. Morrison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>- -</i>		16. SOCIAL SECURITY NO. <i>155-36-5672</i>	
17. INFORMANT <i>Mrs. George D. Becker - Bowie, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> 6000 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>SUPPURATION & PYELONEPHROSIS</i> DUE TO (c) <i>CHRONIC RENAL FAILURE & OBSCURE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2100 HRS.</i> <i>25 DAYS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>COPD, DIABETES & PROLONGED ILL DISEASE</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/30/66</i> to <i>9/6/66</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/4/66</i> , 19 <i>66</i> , and that death occurred at <i>12:00 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harold Blum</i>		22b. DATE SIGNED <i>9-25-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Harold Blum, M.D.</i>		22d. ADDRESS <i>1502 UNIV. BLVD., HYATTSVILLE, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>9-26-1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Vineland, N.J.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. RECORD BY REGISTRAR <i>SEP 27 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>		25c. ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. DC.</i>	

1891

1891

COLLECTION

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK	
c. LENGTH OF STAY IN 1b 4 MONTHS		d. STREET ADDRESS 4626 KNOX RD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2101 FAIRLAND ROAD FAIRLAND NRSG HOME SILVER SPRING		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES EDWARD DUDLEY	4. DATE OF DEATH Month Day Year SEPT 3 1966		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9 1877
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. CONDUCTOR (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Dudley		14. MOTHER'S MAIDEN NAME Mary Headrick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Arthur M. Dudley (son)		Address 4626 Knox Rd. College Park Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Cerebral Thromboses OUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 to 9/3 , 19 66 , that (I) (we) last saw the deceased alive on 9/1/66 19 66 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph E. Smith, Jr.		22b. DATE SIGNED 9/3/66	
22c. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr.		22d. ADDRESS Burtonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept 7 1966	23c. NAME OF CEMETERY OR CREMATORY Oakwood	23d. LOCATION (City, town or county) (State) Charlottesville Va
24. FUNERAL DIRECTOR J. Arthur Waters		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 254 Carroll Street N.W. Washington, D.C. 20032		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE SEP 7 1966			

MEDICAL CERTIFICATION

13985

13985

13985

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>DoA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lumber Shed - Baltimore Ave.</u>		d. STREET ADDRESS <u>No fixed address.</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>D</u> Last <u>Durbin</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	XXXXXX NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7. DATE OF BIRTH <u>9/26/13</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Lansville Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEO S. DURBIN</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES PARKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>10115 Patricia Bessie Rockville</u> <u>Lambert Durbin - Brother Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis -</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>12 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>		19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/15/66</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-19-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15303

THE UNIVERSITY OF CHICAGO

1900

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Chicago" are faintly visible.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 382 10-3 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12910

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12904

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 14920 Peach Orchard Rd.	
3. NAME OF DECEASED (Type or print) Oden First Middle Last Dwyer		4. DATE OF DEATH Month 9 Day 19 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/86
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welfare - 15 yrs.	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-18-9599T		17. INFORMANT Address Neice & Personal effects., Olney, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage due DUE TO 903.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) to fall at home DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased fell while carrying water pail into house.
20c. TIME OF INJURY Month, Day, Year Hour 3:30 p.m. 9-19 19 66	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Spring Montg Md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/23/66	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or Town) (County) (State) Highland, Md.	
24. FUNERAL DIRECTOR F.C. Higginbotham		25a. REC'D BY REGISTRAR SEP 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 9-20-1966	

15804

STATION 15804 - 15804

15804

15804 - 15804

15804 - 15804

15804

15804

15804

15804

15804 - 15804

15804

15804

15804 - 15804

15804

15804

15804

15804

15804

15804 - 15804

15804 - 15804

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12911 CERTIFICATE OF DEATH 12905

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 7721 EASTERN AVE., #12	
3. NAME OF DECEASED (Type or print) First: CHARLES Middle: D. Last: EBEL		4. DATE OF DEATH Month: SEPTEMBER Day: 19 Year: 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 19, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months: 8 Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-WHITE HOUSE U.S. GOV'T.....		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES E. EBEL		14. MOTHER'S MAIDEN NAME MARIE EGLOFF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. MARIE E. SMITH=SANDY SPRING, MARYLA		Address ND.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 159X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal of Pulmonary Edema (c) Obstruction of Arteries DUE TO (c) Rupture of Aorta INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month 1 yr.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/26/66, 1966, to 9/19, 1966, that (I) (we) last saw the deceased alive on 9/18, 1966, and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Francis X. Richardson		22b. DATE SIGNED 9/19/66	
22c. PHYSICIAN'S NAME (Type) Francis X. Richardson, M.D.		22d. ADDRESS 11412 Viersmille Rd., Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/22/1966	
23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR HYSONG FUNERAL HOME 1300 N. ST., N.W. WASH. D.C.		25a. REC'D BY REGISTRAR DATE SEP 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15805

15805

1987.05.20.1501

STANDARD - 100% COTTON

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

VR A15 (4)
20M 1/65

12912

12900

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2013 Chapman Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Thomas Last Eicholtz		4. DATE OF DEATH Month September Day 30 Year 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 May 1910	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY County Government	
11. BIRTHPLACE (County & State, or foreign country) Philippine Islands		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Eicholtz		14. MOTHER'S MAIDEN NAME Lucretia Morgan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-30-5597	
17. INFORMANT Medical Records, WWII & Korean		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO (b) Undifferentiated Lymphoma DUE TO (c) decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exogenous compression of common bile duct with hepatocellular		INTERVAL BETWEEN ONSET AND DEATH 1 week 11 months 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from Sept. 15 , 19 66 , to Sept. 30 , 19 66 , that XX (we) last saw the deceased alive on Sept. 30 , 19 66 , and that death occurred at 905 M. from the causes and on the date stated above.			
22a. SIGNATURE Martin H. Cohen		22b. DATE SIGNED 30 Sept. 1966	
22c. PHYSICIAN'S NAME (Type) Martin H. Cohen, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR San Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 5732 Georgia Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 4 1966			

2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12913 CERTIFICATE OF DEATH 12907

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium.</u>		d. STREET ADDRESS <u>9419 Wire Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Lolita</u> Middle <u>Gladys</u> Last <u>Eschenburg</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 May 1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes</u>	
13. FATHER'S NAME <u>Donald Wedman</u>		14. MOTHER'S MAIDEN NAME <u>Edith MacGordy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>128-097231</u>	
17. INFORMANT <u>Charles G. Eschenburg</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, uterus</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; A.S.H.D.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 9-1966</u> to <u>9-30-66</u> , that (I) (we) last saw the deceased alive on <u>9-29-66</u> , and that death occurred at <u>3A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>D. L. Sangstach M.D.</u>		22b. DATE SIGNED <u>9/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>George F. Sangstach</u>		22d. ADDRESS <u>9241 Columbia Blvd, S. L. Sprg. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-3-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS COMPANY</u>		25a. REC'D BY REGISTRAR <u>Riverdale, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 3 1966</u>	

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

12007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 2/9/63 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BELMONT NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 714 - Elder St. NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle C Last FAUST		4. DATE OF DEATH Month 9 Day 14 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-1883
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVT. CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOVT.	
11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOS. W. COTTER		14. MOTHER'S MAIDEN NAME POORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT SISTER		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA and NANITION 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS, ABDOMINAL (c) CARCINOMA, COLON PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIO SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 1 yr. 18 mo. 18 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 9, 1963 to Sep 14, 1966 , that (I) (we) last saw the deceased alive on 7/30, 1966 , and that death occurred at 4:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 9-14-66	
22c. PHYSICIAN'S NAME (Type) DONALD R. LEWIS		22d. ADDRESS 700 CLOVERLY SILVER SPR. MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep 20, 1966	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Annapolis MD	
24. FUNERAL DIRECTOR Funeral Home Inc		25. REC'D BY REGISTRAR SEP 13 1966	
25a. ADDRESS 254 Convent St. NW, Wash. D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

1300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12915

12909

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Glen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Nursing Home</u>		d. STREET ADDRESS <u>708 Brentford Ave S.S. Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Mamie</u> First <u>Ferguson</u> Middle <u>V</u> Last		4. DATE OF DEATH <u>Sept. 13</u> Month <u>13</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/1876</u>
9. AGE (In years last birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Mann</u>		14. MOTHER'S MAIDEN NAME <u>Emma King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-52-8175</u>	
17. INFORMANT <u>Mrs. Dora Kochler</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5705 Intestinal Hemorrhage</u> DUE TO (b) <u>Intestinal Obstruction</u> DUE TO (c) <u>Adhesions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>58</u> to <u>Sept. 13</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Sept. 11</u> , 19 <u>66</u> , and that death occurred at <u>10:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R. T. Thibadeau</u>		22b. DATE SIGNED <u>Sept. 13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>11000 Old Surge Town Rd. Beltsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE THEREOF <u>9/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR <u>W. R. Hunneman & Son</u> ADDRESS <u>5152 Georgia Ave N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

prest

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12916

CERTIFICATE OF DEATH

12916

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>215.Crestmoor Circle</u>		d. STREET ADDRESS <u>215.Crestmoor Circle</u>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>C.</u> Last <u>FERNOW</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16th</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11. 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Joseph Clements</u>		14. MOTHER'S MAIDEN NAME <u>Grace Reade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Byron A. Barnes same as one</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Rheumatic Heart Disease</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>80 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>62</u> , to <u>9-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> 19 <u>66</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John A. Barnes</u>		22b. DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>Wash. Clinic, Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9.17.66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300.4th st N E Wash.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15410

15410

15410



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN b <u>2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14005 Cove Lane, Apt. # 104</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>14005 Cove Lane Apt. # 104</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Grace</u>			First <u>Bristol</u>		Middle <u>Fletcher</u>		Last <u></u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1966</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3, 1900</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>William W. Rollow</u>					14. MOTHER'S MAIDEN NAME <u>Jeannette Childs</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-30-5619T</u>		17. INFORMANT <u>Mr. Paul R. Fletcher</u> Address <u>14005 Cove Lane Rockville, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary carcinoma of cervix</u> <u>1550</u> DUE TO (b) <u>c metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/10/66</u> to <u>9/23/66</u> , that (I) (we) last saw the deceased alive on <u>9/23/66</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>E. Stuart Lyddane</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/23/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane, M.D.</u>						22d. ADDRESS <u>3066 2 Street, N. W. Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sep. 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>				
24. FUNERAL DIRECTOR <u>Glen Carter</u> ADDRESS <u>434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11091

REPORT OF DEATH

11091

Decedent's Name: [Illegible] Date of Death: [Illegible]

Place of Birth: [Illegible] Age at Death: [Illegible]

Decedent's Address: [Illegible] City: [Illegible] State: [Illegible]

Decedent's Occupation: [Illegible] Cause of Death: [Illegible]

Decedent's Marital Status: [Illegible] Date of Marriage: [Illegible]

Decedent's Education: [Illegible] School Graduated: [Illegible]

Decedent's Religion: [Illegible] Burial Place: [Illegible]

Decedent's Last Will and Testament: [Illegible]

Decedent's Next of Kin: [Illegible]

Decedent's Social Security Number: [Illegible]

Decedent's Date of Birth: [Illegible]

Decedent's Date of Death: [Illegible]

Decedent's Date of Burial: [Illegible]

Decedent's Date of Interment: [Illegible]

Decedent's Date of Cremation: [Illegible]

Decedent's Date of Disposition: [Illegible]

Decedent's Date of Final Disposition: [Illegible]

Decedent's Date of Final Disposition: [Illegible]

Decedent's Date of Final Disposition: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 1
M
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12918

12912

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>38 hrs 35 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4416 TESSENDEN ST NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>H.</u> Last <u>FORBES</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-97</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATENT ATTORNEY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOENMAKER + MATHARE</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Forbes</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Hines</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-03-7533</u>		17. INFORMANT <u>Wife</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute, severe</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary artery insufficiency, mod.</u> DUE TO <u>11 yrs.</u> (c) <u>Coronary arteriosclerosis</u> DUE TO <u>11 yrs +</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>50</u> , to <u>Sept 25</u> , 1966, that (I) (we) last saw the deceased alive on <u>Sept 24</u> 1966, and that death occurred at <u>3:55 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 25 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>				22d. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>Sept. 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or Town) <u>Washington</u> (County) _____ (State) <u>D.C.</u>	
24. FUNERAL DIRECTOR <u>LIVES FUNERAL HOME</u> ADDRESS <u>2547 Wilson Blvd. Arlington, Va.</u>				25a. REC'D BY REGISTRAR <u>SEP 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15015

STATE OF TEXAS

15015

[Faint, illegible text and markings, possibly a signature or stamp, are visible in the center of the page.]

[Faint, illegible text is visible along the right edge of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12919

CERTIFICATE OF DEATH

12913

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Mildred Lee Ford		4. DATE OF DEATH Month Day Year September 28 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1881
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Mr. Howard Thompson		14. MOTHER'S MAIDEN NAME Elizabeth Bolden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-56-6268	
17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary Emphysema, Cerebral Thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 Sep 19 66 to 28 Sep 19 66 that (I) (we) lost the deceased alive on 27 Sep 19 66 and that death occurred at 2:30 AM from causes and on the date stated above.			
22a. SIGNATURE Thomas P. Fogarty		22b. DATE SIGNED 28 Sep 66	
22c. PHYSICIAN'S NAME (Type) Thomas P. Fogarty		22d. ADDRESS Takoma, Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/66	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE SEP 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12013

12013

12013

12013

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12914

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Effie May Forristall		4. DATE OF DEATH Month Day Year 9-28-66 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1872
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Fitts		14. MOTHER'S MARRIED NAME Emma Marden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -- -- -- -- --	
17. INFORMANT Hospital Admission Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Acute myocardial insufficiency; DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 9-28-66			
ACTUAL SIGNATURE Belden R. Reap, M.D.		22. DATE SIGNED 9-29-1966	
EXAMINER'S NAME (Type) Belden R. Reap, M.D.		Address (Street, city, town, or county) Wheaton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-1-1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Joseph Gabler's Sons, Inc.		25a. REC'D BY REGISTRAR OCT 5 1966	
Address 5130 Wisc. Ave. N.W. Wash. D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12921

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

997

998

999

1000

12921

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

15012

STATE OF TEXAS

15012

Blank lined form with two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12222

12916

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>615 Silver Spring Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>615 Silver Spring Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>(NM)</u> Last <u>Frey</u>				4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1882</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired sculptor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Art</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Frey</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Stegherr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>578-12-1757</u>		17. INFORMANT <u>Mrs. Marie Frey</u> <u>615 Silver Spring Avenue</u> <u>Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of prostate & metastases</u> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1954</u> to <u>30 Sept</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>23 Sept</u> , 19 <u>66</u> , and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. And</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>				22d. ADDRESS <u>9006 Colesville Rd., S. S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>845 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE			

aresi

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12823

12917

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Agnes O. Fugitt</u>		4. DATE OF DEATH <u>Sept 21 1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/1872</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geoff Wink</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Goodrich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-14-0364</u>	
17. INFORMANT <u>Mrs E Fugitt</u>		Address <u>daughter-in-law</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute + Chronic</u> Sudden 9070 DUE TO (b) <u>Cardio Vascular Disease</u> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arterio Sclerosis Generalized</u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Left Hip</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at home causing fracture of left hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>9/16 1966</u> Hour <u>9:30</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/21/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/24/1966</u>	
23c. NAME OF CEMETERY <u>Rock Creek</u>		23d. LOCATION (City or Town) <u>Washington, D.C.</u> (County) (State)	
24. FUNERAL DIRECTOR <u>Chevy Chase Funeral Home, Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1891

1891

1 (M)

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DP - Cleared only by Dr. Rogers

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

12924

12918

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>-</u> Last <u>GAITHER</u>				4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/5/02</u>	
9. AGE (In years last birthday) <u>64 yrs.</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min. <u>15</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>SAMUEL Gaither</u>				14. MOTHER'S MAIDEN NAME <u>Rosetta Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>N. Vaughn - Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspirin - Cerebral Infarction</u> (c) <u>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6d</u> <u>3 wks.</u> <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/66</u> to <u>9/8/66</u> , that (I) (we) last saw the deceased alive on <u>9/7/66</u> , and that death occurred at <u>9:40 AM</u> from the causes and on the date stated above.							22b. DATE SIGNED <u>9/8/66</u>
22a. SIGNATURE <u>[Signature]</u>				22c. PHYSICIAN'S NAME (Type) <u>R. L. Snowden</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SANDYSPRING</u>		23d. LOCATION (City, town or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>R. L. Snowden</u>				25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

1531



1531

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12925

CERTIFICATE OF DEATH

12919

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS BENTLEY ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HANNAH Middle BALL Last GILPIN				4. DATE OF DEATH Month 9 Day 9 Year 19 66			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-98	
9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ENGLAND	
12. CITIZEN OF WHAT COUNTRY? England				13. FATHER'S NAME WALTER BALL			
14. MOTHER'S MAIDEN NAME HANNAH BENNETT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT MEDICAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1621 (c)							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/27 , 19 66 , to 9/9 , 19 66 , that (I) (we) last saw the deceased alive on 9/8 , 19 66 , and that death occurred at 8:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-9-66	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-66		23c. NAME OF CEMETERY OR CREMATORY Friends		23d. LOCATION (City or Town) (County) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonville, Md.				25a. REC'D BY REGISTRAR SEP 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

12019

RECEIVED BY THE

12019

M

Sandy Springs, Ga.

Friends

9-12-55

Dear

Francis H. Barber, Newtonville, Ga.

RECEIVED BY THE
12019
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12326

CERTIFICATE OF DEATH

12920

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle	
c. LENGTH OF STAY IN lb 29 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS Box 152	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Lorenz Last GLENN		4. DATE OF DEATH Month September Day 9 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 2, 1906
9. AGE (In years lost birthday) yrs. 59		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Stanton, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Glenn		14. MOTHER'S MAIDEN NAME Elizabeth Pratt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 223 38 2297	
17. INFORMANT Mrs. Jean Glenn, Box 152, Triangle, Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Artery Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 465x DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that Dr. (this hospital) attended the deceased from Aug. 11 , 19 66 , to Sept. 9 , 19 66 , that we last saw the deceased alive on Sept. 9 , 19 66 , and that death occurred at 6:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE J. E. DAVIS		22b. DATE SIGNED Sept. 10, 1966	
22c. PHYSICIAN'S NAME (Type) J. E. DAVIS, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Cunningham Mountcastle Funeral Home, Woodbridge Virginia		25a. REC'D BY REGISTRAR SEP 14 1966	
25b. REGISTRAR'S SIGNATURE f Charles Judge			

12030

12030

OFFICE OF THE

RECORDS

RECORDS

RECORDS

RECORDS

U. S. Naval Hospital, Bethesda, Maryland

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

John L. Brown

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12927

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 717 University Blvd. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otho Middle Lost Stephen Goldsborough		4. DATE OF DEATH Month Sept Day 28 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1894	9. AGE (In years - last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capital Transit Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Leonardtown, Md.	
13. FATHER'S NAME George W. Goldsborough		14. MOTHER'S MAIDEN NAME Fannie Russell		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO None		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Mr. E. A. Manuel Address 8614 Garland Ave. Takoma Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation, giant gastric-peptic ulcer DUE TO (b) with peritonitis DUE TO (c) Bronchopneumonia, acute 540-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Belden R. Keap M.D. EXAMINER'S NAME (Type) BELDEN R. KEAP M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION (City or Town) Prince Georges Co., Md.		23e. REC'D BY REGISTRAR OCT 3 1966		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc. Address 4834 Georgia Ave. Silver Spring, Md.					

22. DATE SIGNED
9-29-1966

15851

ADDITIONAL EXHIBIT - CONTINUOUS RECORD

15851

2011-01-05

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

129228

12922

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i> c. LENGTH OF STAY IN lb <i>D.O.A.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San + Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Michigan</i> b. COUNTY <i>Kent</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Grand Rapids</i> d. STREET ADDRESS <i>1121 Brookview Dr.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ida Elizabeth Good</i>		4. DATE OF DEATH Month <i>9</i> Day <i>1</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-16-1875</i>
9. AGE (In years last birthday) <i>91</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	11. IF UNDER 24 HRS. Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William D Owen</i>		14. MOTHER'S MAIDEN NAME <i>Sidney B. Gibbs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Michigan</i> <i>Mrs Ruth DeVries (Daughter)</i>		Address <i>Grand Rapids</i>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease.</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Selden R. Reap</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELOEN R. REAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 5, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Concord Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Meoga, Illinois</i>	
24. FUNERAL DIRECTOR <i>Clark E. Warner</i> <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>SEP 7 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		22. DATE SIGNED <i>Sept. 1, 1966</i>	

13028

13028



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12929

12923

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6613 Elgin Lane		d. STREET ADDRESS 6613 Elgin Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mildred Ashley Gould		4. DATE OF DEATH Month September Day 29 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1889
9. AGE (In years birth day) 77 yrs		IF UNDER 1 YEAR Months 5 Days 11	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME A. Davis Ashley		14. MOTHER'S MAIDEN NAME Carrie L. Morse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-46-0673	
17. INFORMANT Husband		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) coronary atherosclerosis DUE TO (c) Sudden death		INTERVAL BETWEEN ONSET AND DEATH Sudden death	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 , to Sept. 29, 1966 , that (I) (we) last saw the deceased alive on Sept. 9, 1966 and that death occurred at 7:20 P M, from causes and on the date stated above.			
22a. SIGNATURE Alban W. Bger M.D.		22b. DATE SIGNED 9/29/66	
22c. PHYSICIAN'S NAME (Type) Alban W. Bger		22d. ADDRESS 1801 Eye St N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10-1-66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 7 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13083

RECEIVED OF DEPT

13083

RECEIVED

RECEIVED

RECEIVED

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

80

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12924

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Smith			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville---Rural				c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chilhowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Franklin Middle Greer Last				4. DATE OF DEATH Month Sept Day 26 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7-1890		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Riley Greer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-05-1616		INFORMANT Address Mrs Dora Greer, Poolesville, R.F.D. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 May , 19 65 , to 26 Sept. , 19 66 , that I last saw the deceased alive on 26 Sept. , 19 66 , and that death occurred at 11:45 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) Barnesville, Md		DATE SIGNED 26 Sept 66	
PHYSICIAN'S NAME (Type) Gordon M. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/66		22c. NAME OF CEMETERY OR CREMATORY Macedonia Church		22d. LOCATION (City, town, or county) (State) Chilhowie, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hillon				ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE SEP 28 1966	
				24b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1 (M)

90

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12931											
12925											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>151</u>						
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					d. STREET ADDRESS <u>5135 Mass. Ave., N.W.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethesda-Chevy Chase Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Ruth P GRISMER</u>					4. DATE OF DEATH <u>Sept. 25 1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1904</u>		9. AGE (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Percival</u>					14. MOTHER'S MAIDEN NAME <u>Dorothy Goff</u>						
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Frank C. Grismer, Husb., Same as #2</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Progressive Cerebral Degeneration</u> (c) <u>5 YRS</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>385K</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> , 19 <u>66</u> , to <u>Sept 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 25</u> , 19 <u>66</u> , and that death occurred at <u>8:00 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Peyton R. Evans Jr.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 25 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Peyton R. Evans Jr.</u>					22d. ADDRESS <u>5401 Western Ave Wash DC 20015</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>					25a. REC'D BY REGISTRAR <u>OCT 5 1966</u>					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12932

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12926

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>P.O. Box 183</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JUNE BRUNK</u> First Middle Last 4. DATE OF DEATH <u>9-14-66</u> Month Day Year		5. SEX <u>Fe</u> 6. COLOR OR RACE <u>Cauc.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-9-03</u> 62 yrs. 9. AGE (In years last birthday) 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Brunk</u>		14. MOTHER'S MAIDEN NAME <u>Bearl Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hosp. Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus secondary to</u> <u>816.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>trauma sustained in</u> (c) <u>auto accident</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased was passenger in auto struck by truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:10</u> <u>p.m.</u> <u>9-2</u> <u>19 66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) (County) (State) <u>Warrenton</u> <u>Virginia</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15086

15086

X

15086

15086

15086

1
M
C
70
I
0
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12933

12927

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY in lb <u>21 hrs 25 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SANDY SPRING</u> d. STREET ADDRESS <u>15-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER LEROY HALL</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP. 17, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY, MARYLAND</u>	
13. FATHER'S NAME <u>WALTER LEROY DINES</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		14. MOTHER'S MAIDEN NAME <u>ELLA LOUISE HALL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u> <u>7735</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Immaturity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 DAY</u>	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> <u>1966</u> , to <u>9/18</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> <u>1966</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Edward J. Teroli</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward J. Teroli</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Sandy Spring, Md.</u>	
25a. REC'D BY REGISTRAR <u>Robert L. Snowden</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12934

12928

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5800 Johnson Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5800 Johnson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BEATRICE E. HAMILTON			4. DATE OF DEATH Month Day Year Sept. 6, 19 66				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1884		9. AGE (In years last birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Canada			
13. FATHER'S NAME Edward Ermatinger			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband Address Same as Item 2. George T. Hamilton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO 5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EMPHYSEMA AND COR PULMONALE DUE TO (c) CHRONIC BRONCHITIS					INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 20 YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>October, 1959</u> , to <u>SEPT. 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 5, 1966</u> , and that death occurred at <u>6 A.</u> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Joseph D. Connor</i>		22b. DATE SIGNED 6 Sept. 1966		22c. PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR			
22d. ADDRESS 9420 Old Georgetown Rd. Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-8-66	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			25a. REC'D BY REGISTRAR DATE SEP 8 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

15934

RECORDS OF THE

15934

W-DO JOURNAL

W-DO JOURNAL

1984-85

1984-85

Journal

Journal

Journal

Journal

1984-85

Journal

1984-85



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12935

12929

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL HALL SANITARIUM.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>910-MASS. AVE. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>REGIA</u> Middle <u>R.</u> Last <u>HANLEIN</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13-1885</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>HUGHESVILLE MD</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY (RE) WPT STORE.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN LAMAR.</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ILE MARR.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>HARRY HANLEIN</u> Address: <u>7304 HILTON AVE. TAKOMA PARK</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL HEMORRHAGE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 6</u> , 19 <u>65</u> , to <u>SEPT 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 5</u> , 19 <u>66</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James J. Lunden</u> M.D.		22b. DATE SIGNED <u>SEPT. 5, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>5206 NORWAY DR, CHEVY CHASE, MD</u>	
23a. BURIAL-CREATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept 15-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Southland Park & Co. Md</u>
24. FUNERAL DIRECTOR <u>John Walter</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		25c. REGISTRAR'S NAME	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15001

STANDARD 10 10000000

10001

10001

10001

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b One day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 5027 Suitland Road, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Clifford Ezra Hanshew			4. DATE OF DEATH September 13 19 66		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11 July 1907 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Hanshew					14. MOTHER'S MAIDEN NAME Mary Cox				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWII, 1942-1943			16. SOCIAL SECURITY NO. 234-01-1046		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple myeloma 2 years 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 19 20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 12 , 19 66 , to Sept. 13 19 66 , that XX (we) last saw the deceased alive on Sept. 13 19 66 , and that death occurred at 10:35 AM from the causes and on the date stated above.									
22a. SIGNATURE Norman S. Lichtenstein					22b. DATE SIGNED Sept. 13, 1966				
22c. PHYSICIAN'S NAME (Type) Norman S. Lichtenstein, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Wallace & Wallace Cemetery Clintoville, W Va.		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. Suitland, Maryland					25a. REC'D BY REGISTRAR SEP 19 1966 25b. REGISTRAR'S SIGNATURE g Charles Judge				

12330

Yes
John F. Henshaw
Carpenter
Male
White
XX
Clifford
Born
Hanshaw
September 13
1905
2617 Rutland Road, S.E.
Bethesda
One day
Bethesda
Maryland
Prince Georges

Yes
11, 1942-1943 124-01-1048
The Clinical Center, Bethesda, Maryland
The Medical Records
Mary Cox
Extensive pulmonary embolism
3 days
Multiple myeloma - 4 years
X-ray
Sept. 13 1905
Sept. 13 1905
Sept. 13 1905
The Clinical Center, Bethesda, Maryland
Institute of Health, Bethesda, Maryland
Norman B. Montmarquet, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>42 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dover</u> d. STREET ADDRESS <u>121 Hazel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Jesse Archie Harman</u> First Middle Last			4. DATE OF DEATH <u>September 1 19 66</u> Month Day Year						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 September 1904</u> yrs.		9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>26</u> IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fuel Oil Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thaddeus S. Harman</u>					14. MOTHER'S MAIDEN NAME <u>Henrietta Crites</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>221-12-1289</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emboli</u> DUE TO (c) <u>Muscular dystrophy</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 July</u> , 19 <u>66</u> , to <u>1 Sept.</u> , 19 <u>66</u> , that <u>XX</u> (we) last saw the deceased alive on <u>1 September</u> 19 <u>66</u> , and that death occurred at <u>11:58</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert C. Griggs</u>						22b. DATE SIGNED <u>11 September 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Griggs, M.D.</u>						22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>			23b. DATE THEREOF <u>9/2/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeside Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Dover, DELAWARE</u>		
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1934

DEPARTMENT OF HEALTH

1934

DEPARTMENT

DEPARTMENT

DEPARTMENT

DEPARTMENT

DEPARTMENT

The Clinical Center, Bethesda, Maryland

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

James H. Brown, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12938

CERTIFICATE OF DEATH

12932

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bowie</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Springs</u>		c. LENGTH OF STAY IN Jb <u>34 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>12908 Beardsdale Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Franklin P. HARRY</u>		4. DATE OF DEATH <u>9 - 5 - 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/31/86</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Supervisor</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME <u>Charles A. Harry</u>		15. MOTHER'S MAIDEN NAME <u>Mary E. James</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>214-44-6450</u>	
18. INFORMANT <u>W. Harry</u>		19. ADDRESS <u>12908 Beardsdale Lane, Bowie, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate & metastasis</u> DUE TO (b) <u>Paralytic illness</u> DUE TO (c) <u>Probably splenic flexure tumor</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21c. (City or town) (County) (State)		21d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 4</u> , 19 <u>66</u> , to <u>SEPT 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 5</u> , 19 <u>66</u> , and that death occurred at <u>10:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Fidel J. Quintana</u>		22b. DATE SIGNED <u>SEP 6, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>FIDEL J. QUINTANA</u>		22d. ADDRESS <u>8323 DRAPER LA, SPRINGFIELD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 8-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Hampton</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Burial Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15035

TESTIMONY OF DEATH

15035

Name of Deceased		Date of Death	
Place of Death		Cause of Death	
Age at Death		Sex	
Occupation		Marital Status	
Signature of Deceased		Signature of Witness	
Signature of Physician		Signature of Coroner	
Signature of Burial Officer		Signature of Registrar	
Signature of Minister		Signature of Undertaker	
Signature of Funeral Home		Signature of Cemetery	
Signature of Mortician		Signature of Embalmer	
Signature of Crematorium		Signature of Interment	
Signature of Burial		Signature of Reinterment	
Signature of Disposition		Signature of Return	
Signature of Final Disposition		Signature of Final Return	

129339

CERTIFICATE OF DEATH

12933

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Bowie			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 9 hrs 7 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital,				d. STREET ADDRESS 13018 Bowie Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Virginia Last Hartwig				4. DATE OF DEATH Month Sept. Day 6 Year 19 66			
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1966	
9. AGE (In years last birthday) yrs. 9		10. IF UNDER 1 YEAR Months 9 Days 7		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Montgomery, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		13. FATHER'S NAME Richard C. Hartwig	
13. FATHER'S NAME Richard C. Hartwig				14. MOTHER'S MAIDEN NAME Joyce Nagel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Laurel Address Md. Mr. Richard C. Hartwig, 13018 Bowie Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraventricular cerebral hemorrhage 7605 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 6 , 19 66 , to Sept. 6 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 6 , 19 66 , and that death occurred at 505PM , from causes and on the date stated above.							
22a. SIGNATURE <i>J. I. Lynch</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8 Sept. 1966	
22c. PHYSICIAN'S NAME (Type) J. I. LYNCH, M.D.				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-9-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR DATE SEP 13 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1505

12851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b <u>16 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PET. WALL NURS HOME - PET. WALL RD</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47-3</u> d. STREET ADDRESS <u>3527 Runnymede Pl., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SABINE</u> First Middle Last			4. DATE OF DEATH <u>SEPT 9 1966</u> Month Day Year			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>12/27/1880</u>			9. AGE (In years last birthday) <u>86</u> yrs.			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Bernhard Harburger</u>					
14. MOTHER'S MAIDEN NAME <u>Flora Kahn</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>					
16. SOCIAL SECURITY NO.						17. INFORMANT <u>Mrs. Frances Lesser 3527 Runnymede Pl. NW</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral infarction</u> DUE TO (b) <u>cerebral thrombosis</u> DUE TO (c) <u>cerebral arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 wk</u> <u>Indef</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gen. arteriosclerosis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>65</u> to <u>7/8</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9/7</u> , 19 <u>66</u> , and that death occurred at <u>7/1</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Stephen N. Jones</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/9/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES-MD</u>						22d. ADDRESS <u>809 - Viers Mill Rd. Rockville Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>9-11-66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Old Mt. Carmel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Cypress Hills Queens, New York</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Danzansky & Sons NW, Wash., D.C.</u>						ADDRESS <u>3501-14th St</u>			25a. REC'D BY REGISTRAR <u>SEP 22 1966</u>		
						25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>					

1951

1951

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

10/1/51

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12941

CERTIFICATE OF DEATH

12935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

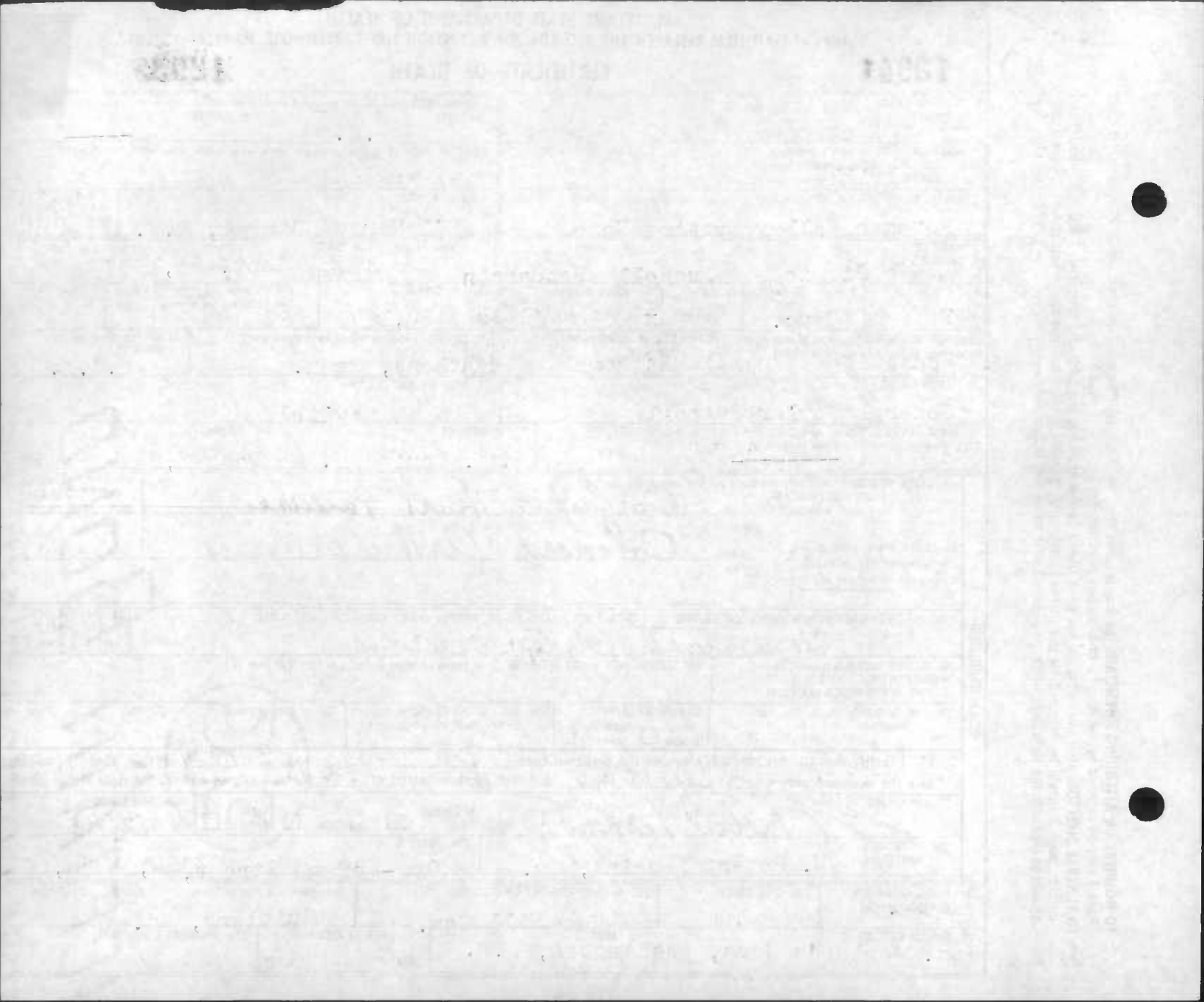
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>4703 Warren Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jimmie Russell Henderson</u>		4. DATE OF DEATH Month Day Year <u>Sept. 24, 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1873</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Athens, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>General Taylor Russell</u>		14. MOTHER'S MAIDEN NAME <u>Emma Mayfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Louise H. Mc Dougal, Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>Sept 24</u> , 1966, that (I) <u>(we)</u> last saw the deceased alive on <u>Sept 18</u> , 1966, and that death occurred at <u>12:41</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W. Robert Perkins, Jr.</u>		22b. DATE SIGNED <u>9/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Robert Perkins, Jr.</u>		22d. ADDRESS <u>4015 - 52 nd Street, NW, Wash, DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

1951

WANT TO TRAIN

1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>7011 17th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Vandalia</u> Last <u>Hill</u>			4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-16-97</u>			9. AGE (In years last birthday) <u>69</u> yrs.			IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>E. Byron Hartman</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth C. Bubb</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>557-56-8257</u>		17. INFORMANT <u>Records - Washington Sanitarium & Hospital</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>157X</u> DUE TO <u>ANOXIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>CARCINOMA OF THE PANCREAS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>WIDE SPREAD METASTASES</u>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>8-21</u> , 19 <u>66</u> , to <u>14 Sept, 1966</u> , that (I) (we) last saw the deceased alive on <u>14 Sept 1966</u> , and that death occurred at <u>330 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>John A Ford</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/14/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN LOUIS FORD MD</u>						22d. ADDRESS <u>831 UNIVERSITY BLVD E. SILVER SPRING MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 17-1966</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>NEITZ VALLEY</u>		23d. LOCATION (City, town or county) (State) <u>Andover Co Penn.</u>					
24. FUNERAL DIRECTOR <u>J. Arthur Walter 254 Carroll St. Takoma Park, Md.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>SEP 16 1966</u>													



[Faint, illegible handwriting in cursive script, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwriting in cursive script, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwriting in cursive script, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
12937										
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>					d. STREET ADDRESS <u>1504 GLEASON ST</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHRYN HEAVER HISSEY</u>					4. DATE OF DEATH Month Day Year <u>Sept. 27 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-21</u>		9. AGE (in years last birthday) <u>45</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM C. CAMPBELL</u>					14. MOTHER'S MAIDEN NAME <u>DOROTHY (UNKNOWN)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>BEAUFORD H. HISSEY - SAME AS #2</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left breast with metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u> </u> , to <u>Sept. 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept. 26</u> , 19 <u>66</u> , and that death occurred at <u>6:04</u> A.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 27, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>					22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/30/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT'L Cem</u>			23d. LOCATION (City, town or county) (State) <u>SUITLAND RD. R. 622 Co. MD</u>			
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. - SILVER SPRING, MD</u>					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>SEP 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

202-101101-1111

THE NEW YORK PUBLIC LIBRARY



1893

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12944

12938

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>3hrs/30mins.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>10305 Brookmoor Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Penelope A.</u> Middle XXXXXXXX Last <u>HOLMES</u>				4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1966</u>									
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-81</u>		9. AGE (in years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Wiley</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jeanne Overton (Same as above # 2)</u> Hospital records									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Acute myocardial disease</u> (c) <u>Chronic myocardial disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>							
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ADDRESS <u>1519 5th Rd., Silver Spring, Md.</u>				22. DATE SIGNED <u>Sept. 11, 1966</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>							
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>							
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Greenbrier				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 100 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ronceverte			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) National Institutes of Health The Clinical Center, Bethesda, Md.					d. STREET ADDRESS P.O. Box 361				
3. NAME OF DECEASED (Type or print) John David Houchins			4. DATE OF DEATH September 7 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 October 1907 58		9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald J. Houchins					14. MOTHER'S MAIDEN NAME Mary Hannah Foglesong				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 1942 235-05-9193		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 30 May , 19 66 to 7 Sept , 19 66 that we last saw the deceased alive on 7 September 19 66 , and that death occurred at 1:30 P. from the causes and on the date stated above.									
22a. SIGNATURE Roland T. Skeel, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7 September 1966		
22c. PHYSICIAN'S NAME (Type) Roland T. Skeel, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sep. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town or county) (State) Ronceverte, West Virginia		
24. FUNERAL DIRECTOR Clark E. Wisor, Warner E. Pumphrey, Inc.					ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR SEP 13 1966		
					25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

13037

13037

West Virginia

However

100

100

However

1.0. Box 301

The Clinical Center, Bethesda, Md.

18 October 1967 28

Male

West Virginia

Chen

Very Warm Reflection

Donald J. Henderson

The Medical Record

The Clinical Center, Bethesda, Maryland

1967-05-02

1967

Yes

1967-05-02

00 7 1967

00 7 1967

7 September 67

The Clinical Center, National

Institute of Health, Bethesda, Md.

1967-05-02

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12946

CERTIFICATE OF DEATH

12940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dwight Middle Eroll Last HUBBARD		4. DATE OF DEATH Month September Day 27 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1921
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 10 Days 26	11. IF UNDER 24 HRS. Hours 10 Min. 26
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13. FATHER'S NAME Dwight K. Hubbard		14. MOTHER'S MAIDEN NAME Vyrl Siron	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1940-1963		16. SOCIAL SECURITY NO. 263 24 9900	
17. INFORMANT Bradington, Fla.		18. ADDRESS Mrs. Mary A. Hubbard, 6615 9th Ave. N.W.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of the lungs with wide-spread metastases. 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Sept. 3 , 19 66 , to Sept. 27 , 19 66 that (X) (we) last saw the deceased alive on Sept. 27 , 19 66 , and that death occurred at 8:15 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>David R. Foreman</i>		22b. DATE SIGNED Sept. 28, 1966	
22c. PHYSICIAN'S NAME (Type) David R. Foreman		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-30-66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR OCT 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 6008 Longfellow Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Thomas HUDSON				4. DATE OF DEATH Month Day Year Sept. 14 19 66			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 1, 1920		9. AGE (In years last birthday) yrs. 46	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Rochester, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 11-7-43 to 8-054-14-0501		17. INFORMANT East Riverdale Address Md. Mrs. Marion Hudson, 6008 Longfellow St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontocerebellar Tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 16 , 19 66 , to 14 Sept. , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 Sept. , 19 66 , and that death occurred at 335P M, from causes and on the date stated above.							
22. SIGNATURE Martin Gregor Andersen				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept. 15, 1966	
22c. PHYSICIAN'S NAME (Type) Martin Gregor Andersen, M.D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 9/19/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin Street, N. W. Washington, D.C.				25a. REC'D BY REGISTRAR SEP 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

15041

15041

1

THE GREAT DEBATE

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

15041

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12948

12942

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10001 Portland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Helen Christine Hufford		4. DATE OF DEATH Month September Day 9 Year 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Housewife	
12. BIRTHPLACE (County & State, or foreign country) Minnesota		13. CITIZEN OF WHAT COUNTRY? American	
14. FATHER'S NAME Mr. Nells Anderson		15. MOTHER'S MAIDEN NAME Martha Johanson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO. 478-34-0432	
18. INFORMANT Patient's chart		Address 578-03-3557-D	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO (b) H EVD & A SVD -DUE TO (c) Diarrhea & Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 19 66 , to Sept 8, 19 66 , that (I) (we) last saw the deceased alive on 7/8 19 66 , and that death occurred at 12:02 AM , from causes and on the date stated above.			
22a. SIGNATURE Marvin Schneider		22b. DATE SIGNED 9/9/66	
22c. PHYSICIAN'S NAME (Type) Marvin Schneider, M.D.		22d. ADDRESS 911 Silver Spring Ave., S.S., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Tran		23b. DATE THEREOF 9/13/66	
23c. NAME OF CEMETERY OR CREMATORY Minnesota Acacia Pk. Cem		23d. LOCATION (City of Town) (County) (State) St. Paul, Minnesota	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Maryland		25. REGISTRAR'S SIGNATURE SEP 13 1966 Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Zhuo Li

23021

540-42-874

10-11-12

1943

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12949

12943

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>735 Plego Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>735 Plego Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARY FRANCES IHRIE</u> First Middle Last				4. DATE OF DEATH <u>Sept 24</u> 19 <u>66</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 29 1894</u> Months Days Yrs.		9. AGE (In years lost birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Francis Collins</u>				14. MOTHER'S MAIDEN NAME <u>Eva Wathen Branson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John R. Ihrie</u> Address <u>(same as #2)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>AUG. 15, 1966</u> to <u>SEPT 24, 1966</u> , that (2) (we) last saw the deceased alive on <u>SEPT 23, 1966</u> , and that death occurred at <u>8:40 P.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>James R. Coleman MD</u>				22b. DATE SIGNED <u>SEPT 24, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MARYLAND</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u>			
24. FUNERAL DIRECTOR <u>J. Arthur Waters, 254 Carroll A NW. 4C</u> ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DATE <u>SEP 27 1966</u>				DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15013

RECEIVED IN NEWARK

15013

15013

15013

15013

15013

15013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 Mos. 16 Da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BETHESDA SILVER SPRING NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5101 Ridgefield Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RUBY</u> Middle <u>ANN</u> Last <u>JACKSON</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>7th</u> Year <u>1966</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 4, 1878</u> 9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>3</u> Min. <u>1966</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTRAR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>BIBLE INSTITUTE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James H. Jackson</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Ann Poling</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>322-28-1766</u> 17. INFORMANT <u>Neice Mrs. Thomas Flavin</u> Address <u>4800 Dover Rd. Washington, D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, basilar artery</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>June, 1965</u> , to <u>7 SEPT, 1966</u> , that (I) (we) last saw the deceased alive on <u>7 SEPT 1966</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Joseph J. Wallace</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7 SEPT. 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. WALLACE, M.D.</u>		22d. ADDRESS <u>5817 LENOX RD. BETHESDA, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-7-66</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Horton Cemetery</u>			
23d. LOCATION (City, town or county) <u>Horton, Kansas.</u>		24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> ADDRESS					
25a. REC'D BY REGISTRAR <u>SEP 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

15017

MONTGOMERY COUNTY

ARMY

JACKSON

WHITE

BIRMINGHAM

U.S.A.

ARMY AND NAVY

ARMY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

ARMY AND NAVY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>13 months</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Springvale Terrace</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>Springvale Terrace</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Helen Frances Jaquith</i>		4. DATE OF DEATH <i>September 27 19 66</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Aug. 24, 1894</i>		9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
11. BIRTHPLACE (County & State, or foreign country) <i>Upton, Massachusetts</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>George H. Evans</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Bates</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) <i>none</i>			
16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT <i>Dr. Richard Jaquith</i>		Address <i>5604 42nd Ave Hyattsville, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4301</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 HRS.</i> <i>5 YRS.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>2/1</i> , 19 <i>65</i> , to <i>9/27</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/27</i> 19 <i>66</i> , and that death occurred at <i>7A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John E. Everett</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/27/66</i>				
22c. PHYSICIAN'S NAME (Type) <i>JOHN E. EVERETT</i>					22d. ADDRESS <i>9400 CONN. AV. KENSINGTON</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 1, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Spencer, Mass.</i>					
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 30 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

15043

15043



CERTIFICATE OF DEATH

12952

12946

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle M Last JARBOE		4. DATE OF DEATH Month 9 Day 20 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/10
9. AGE (In years lost birthday) 56 Yrs.		10. IF UNDER 1 YEAR Months 3 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 5
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Director G.S.A. U. S. Gov't		13. KIND OF BUSINESS OR INDUSTRY U. S. Gov't	
14. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. FATHER'S NAME George M. Mattingly		17. MOTHER'S MAIDEN NAME Leocadia J. Lally	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		19. SOCIAL SECURITY NO. none	
20. INFORMANT William D. Jarboe		Address 1961 Seminary Place	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY DUE TO (b) PULMONARY EMPHYSEMA & FIBROSIS DUE TO (c) IRRADIATION FOR INOP. CA. BREAST			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED METASTATIC BREAST CARCINOMA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DECEMBER 1960 to 9-20, 1966 that (I) was last saw the deceased alive on 9-19, 1966 , and that death occurred at 9:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE John P. Haberlin		22b. DATE SIGNED 9-20-66	
22c. PHYSICIAN'S NAME (Type) John P. Haberlin		22d. ADDRESS 1015 Spring St. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/23/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR The S. H. Hines Company		ADDRESS Washington, DC	
25a. REC'D BY REGISTRAR SEP 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4451

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12947

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dubuque</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>			d. STREET ADDRESS <u>7405 Carroll Ave., T.P., Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Emma Johnson</u>			4. DATE OF DEATH Month Day Year <u>9-24-66</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-88</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>Robert F. Rock</u>			14. MOTHER'S MAIDEN NAME <u>Emma S. Sandy</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO (b) <u>accompanied by acute bronchopneumonia</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>9-24-1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, Town, or County) <u>Chesapeake, Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 27-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City or Town) (County) (State) <u>Chesapeake Va.</u>	
24. FUNERAL DIRECTOR <u>Arthur Tatters</u>		ADDRESS <u>254 Carroll St</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15843

2028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
12954					12948							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY Montgomery					a. STATE District of Columbia							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					b. COUNTY District of Columbia							
c. LENGTH OF STAY IN 1b 2 Days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland					d. STREET ADDRESS Apt. 5 5010 Southern Avenue, S.E.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) Silvia			First Catalina			Middle Johnson			Last			
4. DATE OF DEATH September 25 1966			Month September			Day 25			Year 1966			
5. SEX Female			6. COLOR OR RACE Negro			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 25 June 1934			
9. AGE (In years last birthday) 32 yrs.			IF UNDER 1 YEAR Months 32			Oays 32			Hours 32			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician			10b. KIND OF BUSINESS OR INDUSTRY Hospital			11. BIRTHPLACE (County & State, or foreign country) Cuba			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wilbur Barnes					14. MOTHER'S MAIDEN NAME Mildred Haywood							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 578-52-9120					17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myelogenous leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 12 hours 1 week		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 September 1966 to 25 September 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 25 September 1966 , and that death occurred at 1240M , from the causes and on the date stated above.												
22a. SIGNATURE Leroy Fass										22b. DATE SIGNED 25 Sept. 1966		
22c. PHYSICIAN'S NAME (Type) Leroy Fass, M.D.										22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 9/28, 1966				23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				
23d. LOCATION (City, town or county) (State) Fort Myer, Virginia				24. FUNERAL DIRECTOR Alex Pope				25a. REC'D BY REGISTRAR SEP 29 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. ADDRESS 414 15th. St. S. E.				25d. DATE SEP 29 1966				

1234

1234

Montgomery

Washington

The Medical Center, Bethesda, Md., Virginia

2000 Randolph Avenue, N.W.

Washington

Division

25 June 1951

Division of Health

Washington

Division of Health

Division of Health

Division of Health

The Medical Center, Bethesda, Md., Virginia

25 June 1951

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12955

12949

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN <u>4 Mos 14 das</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PENNA</u> b. COUNTY <u>Delaware</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALDEN</u> d. STREET ADDRESS <u>221 Merion Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DAVID E JONES</u> First Middle Last			4. DATE OF DEATH <u>Sept 7 1966</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 27 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County, State, or foreign country) <u>Philadelphia, PENNA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>DAVID T JONES</u>				
14. MOTHER'S MARDEN NAME <u>ELIZABETH WHITTE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>162-10-7990</u>			17. INFORMANT <u>Alice R. Jones Same as #2 wife</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized A.S.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus. Ess. Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>4-27 1966</u> to <u>9-7 1966</u> that (I) (we) last saw the deceased alive on <u>9-7 1966</u> and that death occurred at <u>2:25 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>D. H. Lengstack M.D.</u>			22b. DATE SIGNED <u>9-7-66</u>		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, ETC. (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/10/66</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Holy Cross</u>			
23d. LOCATION (City or Town) <u>Yeodon</u>		23e. (County) _____		23f. (State) <u>Pa.</u>			
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>			25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			25c. ADDRESS <u>Hyattsville, Md.</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13047

STATE OF TEXAS

13047

David T. Jones
El Paso, Texas
His Honor, Judge
County of El Paso, Texas
David T. Jones
El Paso, Texas
His Honor, Judge
County of El Paso, Texas
David T. Jones
El Paso, Texas
His Honor, Judge
County of El Paso, Texas

David T. Jones
El Paso, Texas
His Honor, Judge
County of El Paso, Texas
David T. Jones
El Paso, Texas
His Honor, Judge
County of El Paso, Texas
David T. Jones
El Paso, Texas
His Honor, Judge
County of El Paso, Texas

DAVID T. JONES
EL PASO, TEXAS
HIS HONOR, JUDGE
COUNTY OF EL PASO, TEXAS
DAVID T. JONES
EL PASO, TEXAS
HIS HONOR, JUDGE
COUNTY OF EL PASO, TEXAS
DAVID T. JONES
EL PASO, TEXAS
HIS HONOR, JUDGE
COUNTY OF EL PASO, TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
129556						12950					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY <i>Montgomery</i>			MARYLAND			a. STATE <i>Washington Dc</i>			b. GOUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Springs Maryland</i>			c. LENGTH OF STAY IN 1b <i>5 days</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>47-3</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital of Silver Springs</i>						d. STREET ADDRESS <i>3602 Quesada St</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Margaret</i>			First Middle Last <i>Jones</i>			4. DATE OF DEATH Month <i>9</i> Day <i>11</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 8/20/9</i>		9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreign Service Officer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>State Dept</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Tennessee</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Albert O. Childs</i>						14. MOTHER'S MAIDEN NAME <i>Constance Gibbs</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Arthur G. Jones</i> Address <i>3602 Quesada St. N.W. Washington, D.C.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Infarction</i> <i>332X</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>	
PART II. OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDICTION GIVEN IN PART I(a)											
20a. AGGIOENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 10</i> , 19 <i>66</i> to <i>Sept 11</i> , 19 <i>66</i> , that (I) last saw the deceased alive on <i>Sept 10</i> , 19 <i>66</i> , and that death occurred at <i>12:04</i> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>James Wegan</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/11/66</i>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>9/12/66</i>		23c. NAME OF GEMETERY OR CREMATORY <i>CEDAR HILL</i>		23d. LOGATION (City, town or county) (State) <i>Southland Md.</i>					
24. FUNERAL DIRECTOR <i>J. N. Ennely</i>				ADDRESS <i>1500 W. Bladock Rd. Alexandria, Va.</i>		25a. REG'D BY REGISTRAR DATE <i>SEP 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

15020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURWYN HEIGHTS</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		d. STREET ADDRESS <u>6208 RUATAN STREET</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>MAY 11 1919</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK ANALYST</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months <u>24</u> Days <u>19</u> Hours <u>66</u> Min.
13. FATHER'S NAME <u>William W Jones</u>		14. MOTHER'S MAIDEN NAME <u>Anna Joyce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>304-18-5811</u>	17. INFORMANT <u>Lucas B. Jones</u> Address <u>Burwyn Heights Md</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute suppurative media otitis & pleuritis</u> DUE TO (b) <u>infarcted myocardial infarction</u> DUE TO (c) <u>Heart failure & papillary embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 weeks</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac arrest</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-23, 1966</u> , to <u>9-24, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-24 1966</u> , and that death occurred at <u>3:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James H. Scully</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9-24-66</u>
22c. PHYSICIAN'S NAME (Type) <u>James H. Scully</u>		22d. ADDRESS <u>1835 Eye St NW Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-28-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery, Va</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>J.A. Mattingly</u>		ADDRESS <u>131-11th St. S.E.</u>	25a. REC'D BY REGISTRAR <u>SEP 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>

1681

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 5007 McCall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Henry Judge First Middle Last 4. DATE OF DEATH Sept 18 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE Cauc 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 21, 1921 9. AGE (In years last birthday) 45 yrs. 10. UNDER 1 YEAR 11. UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 10b. KIND OF BUSINESS OR INDUSTRY Automotive parts 11. BIRTHPLACE (County & State, or foreign country) Cambridge, Massachusetts 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Rowland A. Judge 14. MOTHER'S MAIDEN NAME Clara Thornton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II 16. SOCIAL SECURITY NO. 029-10-4856 17. INFORMANT Mrs. Louise Judge Address 5007 McCall Street Rockville, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium (400 cc) & Cardiac tamponade (port wall left ventricle) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured myocardial infarction DUE TO (c) Coronary thrombosis (left circumflex) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 9/14 , 19 66 to 9/18 , 19 66 , that (II) (we) last saw the deceased alive on 9/18 , 19 66 (and that death occurred at 1:35 P.M., from the causes and on the date stated above.		22a. SIGNATURE Morton Shapiro M.O. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/14/66	
22c. PHYSICIAN'S NAME (Type) Morton Shapiro, M.D. 22d. ADDRESS 8107 Eastern Ave., Silver Spring, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sep. 19, 1966 23c. NAME OF CEMETERY OR CREMATORY Forestdale Cemetery 23d. LOCATION (City, town or county) (State) Malden, Massachusetts	
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR SEP 19 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12959

CERTIFICATE OF DEATH

12953

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>7-26-66 to 9-15-66</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>					d. STREET ADDRESS <u>909 HIGHLAND DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>I.</u> Last <u>KANODE</u>				4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-13-81</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Randall</u>				14. MOTHER'S MAIDEN NAME <u>Martha Kanode</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-44-7946-7</u>		17. INFORMANT <u>Esther K. Allen</u>			
18. ADDRESS <u>909 Highland Drive Silver Spring, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>8 mos.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) <u>1) Fracture neck 2nd femur 2) Decubiti hips</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>slip/fall at home 3 AM 7/26/66</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3</u> p.m. <u>7/26 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>SILVER SPRING MONT. MD.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/26, 1966</u> , to <u>9/15, 1966</u> , that (I) (we) last saw the deceased alive on <u>9/15, 1966</u> , and that death occurred at <u>2:50 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Norman Oliver</u>				22b. DATE SIGNED <u>9-15-66</u>		22c. PHYSICIAN'S NAME (Type) <u>NORMAN OLIVER</u>	
22d. ADDRESS <u>1400 SPRING ST. S.S. MONT. MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Purphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

- Closed with medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15353

UNITED STATES OF AMERICA

15353

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12960

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12954

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maria Middle Pauls Last Karras		4. DATE OF DEATH Month September Day 20 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/94
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Messick, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Pauls		14. MOTHER'S MAIDEN NAME BESSIE FIDGELY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Daughter, Mrs. Margaret O'Boyle		Address 12907 Margot Dr Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm, left common iliac artery DUE TO (b) with intraabdominal hemorrhage. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 9-21-1966	
Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 23 SEPT 1966	
23c. NAME OF CEMETERY OR CREMATORY CENWOOD CEMETERY		23d. LOCATION (City or Town) (County) (State) WASHINGTON DC	
24. FUNERAL DIRECTOR CHARLES JUDGE		25a. REC'D BY REGISTRAR SEP 23 1966	
Address 7400 GEORGIA AVE., N.W. DC 20012		25b. REGISTRAR'S SIGNATURE Charles Judge	

15024

UNITED STATES DEPARTMENT OF AGRICULTURE

15024

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1
6

12961

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12955

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>9311 WENDELL ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>Genevieve</u> Last <u>KEATING</u>				4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/96</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Statistical Clerk U. S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Maurice J. O'Connor</u>				14. MOTHER'S MAIDEN NAME <u>Ella V. Cunningham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. David O'Connor</u>		Address <u>9211 Wendell St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1966</u> to <u>Sept 2, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Sept 1, 1966</u> , and that death occurred at <u>9:44</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-2-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>217 WINDY BLVD. SILVER SPRING MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Clark & W. Clark E. Wisor</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13051

RECEIVED

13051

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "13051" are visible.]

[Vertical text on the right margin, likely bleed-through from the reverse side. Some words like "RECEIVED" and "13051" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Apt. 107 1320 Nicholson St., N.W. /	
3. NAME OF DECEASED (Type or print) First Samuel Middle Lee Last KEMP		4. DATE OF DEATH Month Sept. Day 7 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1943
9. AGE (In years last birthday) yrs. 22		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kemp		14. MOTHER'S MAIDEN NAME MARTHA GOODWIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 8-5-64 to 9-7-66		16. SOCIAL SECURITY NO. 578 56 0141	
17. INFORMANT Apt. 107 Washington		Address D.C. Mrs. Delores Kemp, 1320 Nicholson St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Serum Hepatitis/ DUE TO Bronchopneumonia and hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) of unknown etiology DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jul. 22 , 19 66 , to Sept. 7 , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 7 , 19 66 , and that death occurred at 4:15 A M, from causes and on the date stated above.			
22a. SIGNATURE Francis C. Johnson M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Francis C. Johnson, M. D.		22b. DATE SIGNED 8 Sept. 1966	
22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D.C.		25a. REC'D BY REGISTRAR DATE SEP 13 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

130254

DEPARTMENT OF DEFENSE

130254

Director of Defense

Director of Defense

Washington

Washington (cont.)

Aug. 1947

H. E. Royal Hospital

130254

Boys

NEW

and

General

130254

22

Oct. 19, 1947

130254

Washington, D. C.

130254

H. E. Royal Hospital

William King

D. E.

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

130254

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				
c. LENGTH OF STAY IN 1b <u>16 days</u>					d. STREET ADDRESS <u>6414 SANDY STREET</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME 2101 FAIRLAND RD</u>									
3. NAME OF DECEASED (Type or print) <u>MILDRED AGATHA KENNEDY</u>					4. DATE OF DEATH <u>SEPT 22 1966</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 10 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>TRINIDAD WEST INDIES</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM A. GUY</u>					14. MOTHER'S MAIDEN NAME <u>BODINGTON, ROSA</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARJORIE J. FISCHER</u> Address <u>LAUREL, MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OIE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Mitostatic Carcinoma</u> (c) <u>Carcinoma Stomach</u>									INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 yr -</u> <u>2 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> , 19 <u>66</u> to <u>9/21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9/21</u> , 19 <u>66</u> , and that death occurred at <u>10:25</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>J. M. Warren</u>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>					22d. ADDRESS <u>Laurel, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Md</u>		
24. FUNERAL DIRECTOR <u>F. Gasche Sons Hyattsville, Md</u>					25a. REC'D BY REGISTRAR <u>SEP 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

15081

15081

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12964 Items 10 & 9 File #381 10/11/66 pc 12958
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT GOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>308 Burnt Mills Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MONICA</u>		4. DATE OF DEATH <u>9 25 19 66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/24/81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Boyoris</u>		14. MOTHER'S MAIDEN NAME <u>Catherine (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>282-10-8320</u>	
17. INFORMANT <u>Mrs. Aldonna Ratchelder</u>		Address <u>308 Burnt Mills Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 29, 1966</u> , to <u>Sept 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 27, 1966</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>9-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNION BLVD E Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 1, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		DATE <u>OCT 3 1966</u>	

13055

Acute myocardial infarction

ASAP

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12965
12959
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McLean d. STREET ADDRESS 6661 Tennyson Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Peter Christian Kessinger				4. DATE OF DEATH Month Day Year September 7 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 September 1958	
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days 7 0		11. IF UNDER 24 HRS. Hours Min. 7 0		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Kessinger				14. MOTHER'S MAIDEN NAME Dale K. Knox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3-5 Days 2 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 August , 19 66 , to 7 September 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 September 19 66 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Norman S. Lichtenstein 22c. PHYSICIAN'S NAME (Type) Norman S. Lichtenstein, MD.				22b. DATE SIGNED 7 September 1966 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-10-1966		23c. NAME OF CEMETERY OR CREMATORY TUCSON ARIZONA		23d. LOCATION (City, town or county) (State) TUCSON ARIZONA	
24. FUNERAL DIRECTOR W.W. Chambers & Co ADDRESS 517-11th St NW Wash D.C.				25a. REC'D BY REGISTRAR SEP 13 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge			

12052

12052

The Clinical Center, Bethesda, Maryland
1001 Research Drive
Bethesda, Maryland
September 7, 1968

Dr. J. H. Brown
The Clinical Center, Bethesda, Maryland
September 7, 1968

Dr. J. H. Brown
The Clinical Center, Bethesda, Maryland
September 7, 1968

Dr. J. H. Brown
The Clinical Center, Bethesda, Maryland
September 7, 1968

Dr. J. H. Brown
The Clinical Center, Bethesda, Maryland
September 7, 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>314 GRANDIN AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET E KETTERMAN</u>		4. DATE OF DEATH <u>SEPTEMBER 10 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1878</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE OURS</u>	
14. MOTHER'S MAIDEN NAME <u>BETTY COLORS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>215-54-5124</u>		17. INFORMANT <u>SON (CHARLES KETTERMAN)</u> Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X Infarction, Multiple Pulmonary</u> DUE TO (b) <u>Pulmonary Embolization</u> DUE TO (c) <u>Fracture left Hip</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary arteriosclerotic heart disease with infarction, old</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fall & fracture of hip at age 83</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S SIGNATURE <u>John S. Rogers</u> M.D. NAME (Type) <u>JOHN S. ROGERS</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>SEP 15 1966</u>	
22. DATE SIGNED <u>SEP 15 1966</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>9-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	
23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg, Md.</u>		24. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13866

212-2121

on

Galtherburg, Mo.

Forest Oak

9-13-66

Worship

SEP 17 1966

Francis H. Barber, Laytonville, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12967

12961

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Reading Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 300 Reading Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRIET ANN CLAGETT KINGDON			4. DATE OF DEATH Month Day Year Sept. 3, 19 66				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1877	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Rockville, Maryland			
13. FATHER'S NAME Richard A. Clagett			14. MOTHER'S MAIDEN NAME Ann M. Ricketts				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-0444		17. INFORMANT Daughter Mary Kingdon Address Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral infarction 333X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral thrombosis DUE TO (c) gen. arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 7 days 2 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Scotoma - 72 of Hip					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2/4, 1957</u> , to <u>9/3, 1966</u> , that (I) (we) lost saw the deceased alive on <u>9/3, 1966</u> , and that death occurred at <u>8:58 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE 		22b. DATE SIGNED 9/4/66					
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d. ADDRESS 809 Veirs Mill Road Rockville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-6-66	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 8 1966		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

12861

OFFICE OF THE

12861

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY



PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

PROPERTY

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12968

CERTIFICATE OF DEATH

12962

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>10039 Frederick Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>L</u> Last <u>Kingsbury</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Henry Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Daughters.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, massive</u> <u>420L</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary arteriosclerosis with thrombosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sep 5</u> , 19 <u>66</u> , to <u>Sep 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEP 13</u> , 19 <u>66</u> , and that death occurred at <u>2:15</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>DeWitt E. DeLawter</u>		22b. DATE SIGNED <u>Sep 14, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELAWTER</u>		22d. ADDRESS <u>8025 ABERDEEN RD BETH. MD MONT</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sep 17, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Saint Marys Church Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Barnesville, Mont Co. Md</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25. RECEIVED BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>Washington St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. DATE <u>SEP 16 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

15005

STATE OF TEXAS

15005

15005

15005

15005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12969

12963

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Rockingham			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 61 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Eugene Last Kline				4. DATE OF DEATH Month September Day 11 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 September 1926	
9. AGE (In years last birthday) 39 yrs.		10. AGE (In years last birthday) 39 yrs.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quarry Worker				10b. KIND OF BUSINESS OR INDUSTRY Mining Company			
13. FATHER'S NAME Neff Kline				14. MOTHER'S MAIDEN NAME Naomi Neff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 230-32-0811			
17. INFORMANT The Medical Records				Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enterobacter Pneumonia 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Bone Marrow Hypoplasia OUE TO (c) Lymphocytic Lymphosarcoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 6 Days 1 month 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 July , 19 66 , to 11 Sept. , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 September 1966 , and that death occurred at 9:30M , from the causes and on the date stated above.							
22a. SIGNATURE Jerry L. Spivak				22b. DATE SIGNED Sept. 11, 1966			
22c. PHYSICIAN'S NAME (Type) Jerry L. Spivak, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-12-66		23b. DATE THEREOF 9-12-66		23c. NAME OF CEMETERY OR CREMATORY Cherry Grove Cem.		23d. LOCATION (City, town or county) (State) Broadway, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR SEP 14 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Natl. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arl., Va.</u>
24. FUNERAL DIRECTOR <u>Goodley Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 1966</u>	
ADDRESS <u>4217 9th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 Sept</u> , 19 <u>66</u> , to <u>27 Sept</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>27 Sept</u> , 19 <u>66</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George A. Armstrong</u>		22b. DATE SIGNED <u>9-27-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>41-3</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Miami Beach</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7340 Harding Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Simon</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/94</u>
9. AGE (In years last birthday) yrs. <u>72</u>		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>air conditioning</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>- unknown</u>		14. MOTHER'S MAIDEN NAME <u>- unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>151-01-5907</u>	
17. INFORMANT <u>Mrs. Alberta Blum,</u>		Address <u>10315 Haywood Dr, Sil Spg, Md</u>	

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
12964

first

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12971											
12965											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Montgomery</i>						a. STATE <i>Md.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>						b. COUNTY <i>Montgomery</i>					
c. LENGTH OF STAY IN 1b <i>10 days</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ulysses Hospital</i>						d. STREET ADDRESS <i>202 Oakton Rd.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>HARRIA L. KNIEDLER</i>						4. DATE OF DEATH <i>9 25 1966</i>					
5. SEX <i>F</i>						6. COLOR OR RACE <i>C</i>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>						8. DATE OF BIRTH <i>7/16/63</i>					
9. AGE (In years last birthday) <i>3 yrs.</i>						10. IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minor</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>HD.</i>					
11. BIRTHPLACE (County & State, or foreign country) <i>MD.</i>						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>MARCELLE V. KNIEDLER</i>						14. MOTHER'S MAIDEN NAME <i>Dorothy Leonard</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT <i>Hareelle V. Kniedler</i>						Address <i>Gaithersburg Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute CARDIAC ARREST</i>											
3441 DUE TO <i>HYPoxic ENCEPHALOPATHY</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>OBSTRUCTIVE Hydrocephalus</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Bilateral Hydrocephalus</i> <i>RUL, RLL pneumonia</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <i>19</i>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <i>15 Sept</i> , 19 <i>66</i> , to <i>25 Sept</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>24 Sept</i> , 19 <i>66</i> , and that death occurred at <i>2:55 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Gary Brecher MD</i> M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <i>Gary Brecher, Md.</i>											
22d. ADDRESS <i>Silverspring Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>											
23b. DATE THEREOF <i>9-27-66</i>											
23c. NAME OF CEMETERY OR CREMATORY <i>St Rose</i>											
23d. LOCATION (City, town or county) (State) <i>Gaithersburg, Md.</i>											
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gantner</i> ADDRESS <i>316 G. Diamond</i>											
25a. REC'D BY REGISTRAR <i>SEP 27 1966</i>											
25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>											

1885

CERTIFICATE OF DEATH

1885

[Faint, illegible text and markings on a form, likely a death certificate. The form contains several lines of text, some of which are underlined, and a large section in the center that appears to be a signature or a large heading. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12972

12966

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		d. STREET ADDRESS 7601 Gaylord Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joanne Patricia KOESTER		4. DATE OF DEATH Month Day Year September 17 19 66	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 March 1964
9. AGE (In years last birthday) 2 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Jacksonville Beach, Fla.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick H. KOESTER		14. MOTHER'S MAIDEN NAME Eileen R. BOBB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Frederick H. KOESTER 7601 Gaylord Dr.		Address Annadale, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from September 13 19 66 , to Sep 17 19 66 , that (X) (we) last saw the deceased alive on Sept. 17 19 66 , and that death occurred at 1215 AM , from causes and on the date stated above.			
22a. SIGNATURE John J. O'BRIEN		22b. DATE SIGNED 1966 September 17,	
22c. PHYSICIAN'S NAME (Type) John J. O'BRIEN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 9/20/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Tyson Wheeler 1331 E. Montgomery Ave, Rockville Maryland		25a. RECD BY REGISTRAR DATE SEP 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

7051

3. *Journal of the American Medical Association*, 277, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674,



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12973 CERTIFICATE OF DEATH 12967

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 151	
c. LENGTH OF STAY IN 1b <u>42 minutes</u>		d. STREET ADDRESS <u>215 UNIVERSITY BLVD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELEANOR D. KOHLER</u>		4. DATE OF DEATH <u>SEPTEMBER 11</u> 19 <u>66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/17/13</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADJUSTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GR. AMER. INS. CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John J. Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Sadie McMullen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Jean J. Ryan</u>		Address <u>3019 Pioneer Ave. Pittsburgh, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>@ 2 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>66</u> , to <u>9-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-11</u> , 19 <u>66</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>9-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNIV BLVD E, SIL. SP, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 15, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Queen of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Pittsburgh, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 15 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1500

1500

1500

1500

1500

1500

1500

1500

1500

1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12974

12968

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Vermont b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marylander Nursing Home		d. STREET ADDRESS 29 Highland Ave.	
3. NAME OF DECEASED (Type or print) LEON B KROMER		4. DATE OF DEATH September 6 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-25-1876
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army - Retired		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) Michigan		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Napolean B. Kromer		15. MOTHER'S MAIDEN NAME Rosetta Suddick	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I & II		17. SOCIAL SECURITY NO. 677-64-4703	
18. INFORMANT Mrs. Jane K. Kean-3825 Warren St. NW.		Address Wash. DC.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydropneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Astasia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 19, 1962 to Sept 6, 1966 , that (I) (we) last saw the deceased alive on 3 Sept 1966 , and that death occurred at 9:30 M. from causes and on the date stated above.			
22a. SIGNATURE John S. Fawcett		22b. DATE SIGNED Sept 6, 1966	
22c. PHYSICIAN'S NAME (Type) Boyd S. Md.		22d. ADDRESS 20720	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 9-07-1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR SEP 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

VR A15 (4)
20 M 1/66

20251

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12975

12969

1. PLACE OF DEATH a. COUNTY <u>montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN lb <u>2 1/2 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Chevy Chase Nursing & Convalescent Center</u>				d. STREET ADDRESS <u>1401 Blair Mill Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Kune</u> Last <u>Kune</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15 1892</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Vilna, Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Bernard Kamermacher</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Metz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>10101 Brock, Dr. Bernard Kune - SILVER SPRING, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart FAILURE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSELEROTIC Heart disease 10 yrs</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> to <u>Sept 4</u> , 19 <u>66</u> that (1) (we) last saw the deceased alive on <u>9/4</u> , 19 <u>66</u> , and that death occurred at <u>3:00</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Morton W Shapero</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morton W Shapero, MD</u>				22d. ADDRESS <u>8107 Eastern Ave Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. CEM. HATTSVILLE MD</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 217-94 St. N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

15300

STATE OF TEXAS

15300



Vertical text on the right margin, likely a library or archival stamp, containing the words "LIBRARY" and "ARCHIVAL" and some illegible numbers and dates.

Handwritten notes and signatures at the bottom of the page, including the name "W. L. ...", the date "10/1/50", and other illegible markings.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12976

12970

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>29 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First <u>Kuykendall</u> , Middle <u>Millie</u> , Last <u>Effie</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/86</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Reaves</u>		14. MOTHER'S MAIDEN NAME <u>Sarah ? Macafee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>1551</u> DUE TO (b) <u>ABDOMINAL CARCINOMA TOSIS</u> DUE TO (c) <u>ADENOCARCINOMA OF GALL BLADDER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>3 MONTHS</u> <u>1 YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STAN</u>	20f. (City or town) (County) (State) <u>66</u> <u>DEPT</u> <u>66</u>
21. I certify that (I) (this hospital) attended the deceased from <u>SEP 2</u> , 19 <u>66</u> , to <u>SEP 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEP 2</u> , 19 <u>66</u> , and that death occurred at <u>8:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles S. Whitaker</u>		22b. DATE SIGNED <u>SEP 7 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, MD.</u>		22d. ADDRESS <u>CLARKSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	23d. LOCATION (City or Town) (County) (State) <u>Sunshine, Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 1966</u>	
ADDRESS <u>Laytons ville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

12570

DEPARTMENT OF DEFENSE

12570

Medical

Medical Records

Home

12570

12570

12570

Sanitation, Inc.

Mr. General

12570

12570

12570

12570

12570

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. L. L. Beldor, M.D., coroner, called and cleared case for death certificate.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #16 Film #G380 9/20/66 pc

12977

CERTIFICATE OF DEATH

12971

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1532 Red Oak Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Shearer Landis		4. DATE OF DEATH Month Sept Day 14 Year 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-19 22, 1919 04 26 yrs.
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME C. Rubie Landis		14. MOTHER'S MAIDEN NAME Norma Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 26 3413	
17. INFORMANT Mrs. Lillian Landis- See- 2 abcd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis with myocardial infarction DUE TO (b) Coronary heart disease with prior infarctions DUE TO (c) 7 years		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 29, 1966 , to Sept 14, 1966 , that (I) (we) last saw the deceased alive on Aug 29, 1966 , and that death occurred at 11:29 M, from causes and on the date stated above.			
22a. SIGNATURE Sydney Leoenthal		22b. DATE SIGNED Sept 14, 1966	
22c. PHYSICIAN'S NAME (Type) Sydney Leoenthal		22d. ADDRESS 9210 Colson Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19-1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR SEP 19 1966	
ADDRESS T. Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE Charles Judge	

15051

15051



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson Rural		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Jesse Middle Melvin Last Lane		4. DATE OF DEATH Month 9 Day 2 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/1909
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg. Concrete Products		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard F. Lane		14. MOTHER'S MAIDEN NAME Susan Mary Travis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-8075	
17. INFORMANT Mrs. Jesse M. Lane		Address Dickerson, Md. R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, Acute DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 March, 1966 , to 2 Sept, 1966 , that I last saw the deceased alive on 2 Sept, 1966 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		DATE SIGNED 2 Sept 66	
PHYSICIAN'S NAME (Type) Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/66	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W C Hatten		24a. REC'D BY REGISTRAR SEP 7 1966	
ADDRESS Barnesville, Md.		24b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1893

THE UNIVERSITY OF CHICAGO

1893

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12973

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 11 YRS c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>934 PHILADELPHIA AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1 d. STREET ADDRESS <u>934 PHILADELPHIA</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS E. LAWLOR</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-01</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>THOMAS P. LAWLOR</u>		14. MOTHER'S MAIDEN NAME <u>IDA SHEPPARD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>MARGARET LAWLOR SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Tongue</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(his hospital)</u> attended the deceased from <u>1959</u> , 19 <u>9-28</u> , 19 <u>66</u> that (I) <u>not</u> saw the deceased alive on <u>9-15</u> 19 <u>66</u> , and that death occurred at <u>7:40p</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u>				22b. DATE SIGNED M.D. <u>9-28-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>				22d. ADDRESS <u>11602 Georgia Ave. Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>SILVER SPRING, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>				25a. REC'D BY REGISTRAR <u>3821-1474 H. W. Wash. D.C.</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>OCT 3 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1937

TESTIMONY OF CLARA

5000

MONTGOMERY

MONTGOMERY

James Smith

James Smith

1st Tennessee Ave

1st Tennessee Ave

Thomas X B. Lumber

Thomas X B. Lumber

2-12-31

MADE WHITE

U.S.A.

U.S. Govt.

RETIRED

1st CHAPMAN

THOMAS P. LUMBER

MARGARET LUMBER SAME BIRTH

He

18-11-11

face of the tower

1937

9-12-31

James Smith
Miss Betty

1102 Georgia Ave. Silver Spring Md.

James Smith 11-1-31 face of tower 1st Tennessee Ave. Silver Spring, Md.

James Smith 11-1-31 face of tower 1st Tennessee Ave. Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b # 3 wks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bella Vista Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 3006 Lindale Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) OSCAR CALVERT LEIZEAR			4. DATE OF DEATH Sept 2, 19 66		5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH July 6, 1883			9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		
10b. KIND OF BUSINESS OR INDUSTRY Farm			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Leizear (deceased)					14. MOTHER'S MAIDEN NAME Kate Calvert				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mrs. Lucile Hixson, Rockville, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4341 DUE TO (b) Congestive heart failure & bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Stroke PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 6/1/66 , 19 66 , to 9/2/66 , 19 66 , that (I) (we) last saw the deceased alive on 9/1/66 , 19 66 , and that death occurred at 12:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Patrick Jameson M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/2/66		
22c. PHYSICIAN'S NAME (Type) Patrick Jameson					22d. ADDRESS 11718 Georgia Ave, Wheaton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery, Burtonsville, Maryland		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland					25a. REC'D BY REGISTRAR SEP 7 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge		

12934

60

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

100 JAMES ST
NEW YORK 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12975
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN 1b <u>4 yr.</u>		d. STREET ADDRESS <u>3525 Woodbine St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3525 Woodbine Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>North</u> Middle <u>Thomas</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/1915</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive-Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Louis Patterson Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Gertrude Dudley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>718-12-8859</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to Hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by clothes line around neck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9/27/1966</u> Hour <u>5</u> am. <u>p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cherry Chase, Mont. Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>9/27/66</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial-transit</u>	<u>9-28-66</u>	<u>Pine View Cemetery</u>	<u>Rocky Mount, No. Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 3, 1966</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: _____

2. Age: _____

3. Sex: _____

4. Date of death: _____

5. Place of death: _____

6. Cause of death: _____

7. Signature of Medical Examiner: _____

8. Signature of Coroner: _____

9. Signature of Registrar: _____

10. Signature of Physician: _____

11. Signature of Nurse: _____

12. Signature of Undertaker: _____

13. Signature of Burial Society: _____

14. Signature of Cemetery: _____

15. Signature of Funeral Home: _____

16. Signature of Mortuary: _____

17. Signature of Embalmer: _____

18. Signature of Preparator: _____

19. Signature of Assistant: _____

20. Signature of Apprentice: _____

21. Signature of Student: _____

22. Signature of Observer: _____

23. Signature of Examiner: _____

24. Signature of Inspector: _____

25. Signature of Auditor: _____

26. Signature of Treasurer: _____

27. Signature of Secretary: _____

28. Signature of Clerk: _____

29. Signature of Stenographer: _____

30. Signature of Messenger: _____

31. Signature of Janitor: _____

32. Signature of Cook: _____

33. Signature of Housekeeper: _____

34. Signature of Laundry: _____

35. Signature of Porter: _____

36. Signature of Watchman: _____

37. Signature of Fireman: _____

38. Signature of Policeman: _____

39. Signature of Soldier: _____

40. Signature of Sailor: _____

41. Signature of Merchant: _____

42. Signature of Farmer: _____

43. Signature of Laborer: _____

44. Signature of Artist: _____

45. Signature of Musician: _____

46. Signature of Actor: _____

47. Signature of Author: _____

48. Signature of Inventor: _____

49. Signature of Engineer: _____

50. Signature of Doctor: _____

51. Signature of Lawyer: _____

52. Signature of Judge: _____

53. Signature of Minister: _____

54. Signature of Priest: _____

55. Signature of Rabbi: _____

56. Signature of Imam: _____

57. Signature of Monk: _____

58. Signature of Nun: _____

59. Signature of Priestess: _____

60. Signature of Shaman: _____

61. Signature of Witch: _____

62. Signature of Wizard: _____

63. Signature of Sorcerer: _____

64. Signature of Enchanter: _____

65. Signature of Magician: _____

66. Signature of Necromancer: _____

67. Signature of Alchemist: _____

68. Signature of Astrologer: _____

69. Signature of Astrologer: _____

70. Signature of Astrologer: _____

71. Signature of Astrologer: _____

72. Signature of Astrologer: _____

73. Signature of Astrologer: _____

74. Signature of Astrologer: _____

75. Signature of Astrologer: _____

76. Signature of Astrologer: _____

77. Signature of Astrologer: _____

78. Signature of Astrologer: _____

79. Signature of Astrologer: _____

80. Signature of Astrologer: _____

81. Signature of Astrologer: _____

82. Signature of Astrologer: _____

83. Signature of Astrologer: _____

84. Signature of Astrologer: _____

85. Signature of Astrologer: _____

86. Signature of Astrologer: _____

87. Signature of Astrologer: _____

88. Signature of Astrologer: _____

89. Signature of Astrologer: _____

90. Signature of Astrologer: _____

91. Signature of Astrologer: _____

92. Signature of Astrologer: _____

93. Signature of Astrologer: _____

94. Signature of Astrologer: _____

95. Signature of Astrologer: _____

96. Signature of Astrologer: _____

97. Signature of Astrologer: _____

98. Signature of Astrologer: _____

99. Signature of Astrologer: _____

100. Signature of Astrologer: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12982

12976

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New York b. COUNTY Bronx 52			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 9-16-66, 9-26-66			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium Hospital				d. STREET ADDRESS 1600 Jessup Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pearl First Lieberman Middle Last				4. DATE OF DEATH Month 9 Day 26 Year 1966			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/10/97	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? United States	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Abraham Schenholz	
14. MOTHER'S MAIDEN NAME Sylvia Chameides				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. -----				17. INFORMANT Hosp. records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 16, 1966 , to Sept 24, 1966 , that (I) (we) last saw the deceased alive on Sept 26, 1966 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Boris Rabkin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 26, 1966	
22c. PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.				22d. ADDRESS 1019 University Blvd. East			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-28-66		23c. NAME OF CEMETERY OR CREMATORY BETH DAVID CEMETERY		23d. LOCATION (City, town or county) (State) ELMONT - L.I. - N.Y.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons				ADDRESS 3501-14th St. NW, Wash. DC		25a. REC'D BY REGISTRAR SEP 28 1966	
				25b. REGISTRAR'S SIGNATURE John Charles Judge			

15836

15836

15836



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12383 CERTIFICATE OF DEATH 12977

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Althea Woodland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha H. Lindsay				4. DATE OF DEATH Month Sept. Day 30 Year 1966			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1876	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		9. AGE (In years last birthday) 89 yrs.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME James Irvin				14. MOTHER'S MAIDEN NAME Bertha Mann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-44-3975		17. INFORMANT Grace Lindsay Address Green Acres, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4208 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 17 mo. 2 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL , 19 61 , to SEPT 30 , 19 66 , that (I) (we) last saw the deceased alive on SEPT. 30 , 19 66 , and that death occurred at 12:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Leo M. Curtis				22b. DATE SIGNED 9-30-66		22c. PHYSICIAN'S NAME (Type) LEO M. CURTIS	
22d. ADDRESS 8218 WISCONSIN AVE., BETHESDA, MD.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/66		23c. NAME OF CEMETERY OR CREMATORY London Park Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Washington, D.C.				25a. REC'D BY REGISTRAR Charles Judge			
25b. REGISTRAR'S SIGNATURE Charles Judge				DATE OCT 5 1966			

1893

1893

Ministry of Colonies

Ministry of Colonies

Colonies

Colonies

1893 at every 100

1893 at every 100

1893 at every 100

1893 at every 100

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

Nov. 11 1893 80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12984

CERTIFICATE OF DEATH

12978

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>8018 Park Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lesa</u> Middle <u>V.</u> Last <u>Lingo</u>			4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1966</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 4/1895</u>	9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Atlanta Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>T. T. Deal</u>			14. MOTHER'S MAIDEN NAME <u>Lena Muller</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-48-5873</u>		17. INFORMANT <u>Charles M. Lingo</u> Address <u>Item 2.</u> <u>Husband - Same as Above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal hemorrhage and insufficiency</u> DUE TO <u>shock</u> DUE TO <u>sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6-15, 1966</u> to <u>9-13, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-13, 1966</u> , and that death occurred at <u>11:45</u> M, from causes on and the date stated above.							
22a. SIGNATURE <u>J. P. McCarrick</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9-14-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>J. P. McCarrick</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Meth. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Potomac, Maryland</u>				
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		ADDRESS <u></u>	25a. REC'D BY REGISTRAR <u>SEP 16 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

15851

UNITED STATES OF AMERICA

15851

MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

15078

CHURCH OF MARY

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

15078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12986

CERTIFICATE OF DEATH

12980

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 4802 Creek Shore Drive	
3. NAME OF DECEASED (Type or print) First Elsie Middle Beatrice Last LOVE		4. DATE OF DEATH Month September Day 29 Year 19 66	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess-cashier		10b. KIND OF BUSINESS OR INDUSTRY New York City, N.Y.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Bukmaier		14. MOTHER'S MAIDEN NAME Mary Rathgeb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Rockville		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS WITH MASSIVE OF METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (t) (this hospital) attended the deceased from Sept. 19, 1966 , to Sept. 29, 1966 , that (t) (we) last saw the deceased alive on Sept. 29, 1966 , and that death occurred at 815 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>J. E. Davis</i>		22b. DATE SIGNED 30 Sept. 1966	
22c. PHYSICIAN'S NAME (Type) J. E. DAVIS LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/66	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Hawthorne, New York	
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE OCT 3 1966	
25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

15880

RECORD OF DEATH

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

15880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12987

12981

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7010 Pyle Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle C Last Loveless		4. DATE OF DEATH Month September Day 4 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 13, 1891
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Schladt		14. MOTHER'S MAIDEN NAME Catherine Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-24-5081	
17. INFORMANT Mrs. Mary Kay- Dtr.-Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO (b) Pulmonary Fibrosis DUE TO (c) Carcinoma of Colon		INTERVAL BETWEEN ONSET AND DEATH months year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 20, 1966 to Sept 2, 1966 , that (I) (we) last saw the deceased alive on Sept 4, 1966 , and that death occurred at 1 PM , from causes and on the date stated above.			
22a. SIGNATURE Lyle Williams		22b. DATE SIGNED Sept 4, 1966	
22c. PHYSICIAN'S NAME (Type) Lyle Williams		22d. ADDRESS 831 University Blvd E. Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/7/66	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem		23d. LOCATION (City or Town) (County) (State) Silver Spring Md	
24. FUNERAL DIRECTOR JOS GAWLER'S SONS, 5130 WIS AVENUE, N.W., WASH, D.C.		25. REC'D BY REGISTRAR SEP 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12988

12982

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Germantown</u>			c. LENGTH OF STAY IN 1b <u>16 years</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>			d. STREET ADDRESS <u>Germantown - Route 1</u>		
3. NAME OF DECEASED (Type or print) <u>Stonestreet Wilson Luhn</u>			4. DATE OF DEATH <u>September 24 1966</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-17-1908</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman on County Road</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Potomac, Md.</u>		
13. FATHER'S NAME <u>George Washington Luhn</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-01-1825</u>		
17. INFORMANT <u>Agnes B. Luhn, Route 1, Germantown, Md.</u>			Address <u></u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 4201 DUE TO (b) <u>Cardiac angina</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept-17-1966</u> to <u>Sept-24-1966</u> , that (I) (we) last saw the deceased alive on <u>Sept-24-1966</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>William C. Miller</u> M.D.			22b. DATE SIGNED <u>Sept-24-1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER, M.D.</u>			22d. ADDRESS <u>7-Brooks Ave., Gaithersburg, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-26-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City, town or county) (State) <u>Beallsville, Mont. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>			25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>		
ADDRESS <u>Laytonsville, Md.</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1885

1885

Beallsville, Mont. Md.

Monocacy

9-25-00

Harjai

Lavoness, Md.

Francis H. Barber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 yrs 3 mons.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home, 1000 Oakview Dr</u>					d. STREET ADDRESS <u>5204 Westwood Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carlotta</u> Middle <u>Lukins</u> Last <u>Lukins</u>					4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Russell</u>					14. MOTHER'S MAIDEN NAME <u>Amarillis Rogers</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>57960-4998</u>		17. INFORMANT <u>Betty Didcott</u>		Address <u>5204 Westwood Dr. Wash D.C. 20016</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Cerebral</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis, Cerebral.</u> DUE TO (c) <u>11 yrs.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>data shown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Secondary</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1966</u> to <u>Sept. 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 31, 1966</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u>Sept. 11, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>9-12-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Paulk Son Wash D.C.</u>						25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
						DATE <u>SEP 19 1966</u>			

12502

12502

DEPARTMENT OF HEALTH

INVESTIGATION OF DEATH

INVESTIGATION OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF HOSPITAL

NAME OF CITY

NAME OF COUNTY

NAME OF STATE

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN ID <u>128 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>70-3</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u> d. STREET ADDRESS <u>313 West University Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Loudon</u> Last <u>MacFadyen</u>			4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>19 66</u>		5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>11 April 1947</u>			9. AGE (In years last birthday) <u>19</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u> </u> Days <u> </u></td> <td>Hours <u> </u> Min. <u> </u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u> </u> Days <u> </u>	Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months <u> </u> Days <u> </u>	Hours <u> </u> Min. <u> </u>																
13. FATHER'S NAME <u>Loudon E. MacFadyen</u>					14. MOTHER'S MAIDEN NAME <u>Violet Ornsby</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Proteus Bronchopneumonia</u> (b) <u>Acute Lymphoblastic Leukemia</u> (c) <u>Renal Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 years</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>29 April</u> , 19 <u>66</u> , to <u>4 Sept.</u> , 1966, that <u>XX</u> (we) last saw the deceased alive on <u>4 September 19 66</u> , and that death occurred at <u>8:45M</u> , from the causes and on the date stated above.								
22a. SIGNATURE <u>Joel J. Rubenstein</u>			22b. DATE SIGNED <u>Sept. 4, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Joel J. Rubenstein, M.D.</u>			22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			23b. DATE THEREOF <u>9/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Orange Co. N.C.</u>		24. FUNERAL DIRECTOR ADDRESS <u>The S.H. Hines Co 2901-14th. St. N.W. D.C.</u>								
25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 8 1966</u>												

12881

12881

John G. Gorman

John G. Gorman

1941-1942

1941-1942

1941-1942

The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

The Clinical Center, Bethesda, Maryland

1941-1942

1941-1942

1941-1942

1941-1942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12991

12985

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 4713 Tallahassee Ave.	
3. NAME OF DECEASED (Type or print) John G. Madden		4. DATE OF DEATH Month Sept Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15, 1910
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months 15 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Lockheed Aircraft	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Madden		14. MOTHER'S MAIDEN NAME Alice Lee Gaither	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 579-03-7990	
17. INFORMANT Mrs. Medora Pelican		Sister: 4713 Tallahassee Ave., Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Sept. 5, 1966	
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, & county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 10, 1966	
23c. NAME OF CEMETERY OR CREMATORY Val Halla Memorial Park		23d. LOCATION (City or town) (County) (State) Monterey, California	
24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR SEP 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12355

MASSACHUSETTS DEPARTMENT OF CORRECTIONS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MASSACHUSETTS

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12992

12986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY in 1b <u>20 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4848 Chevy Chase Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lila</u> Middle <u>Marie</u> Last <u>MAKI</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>June 24, 1907</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR RELATIONS BOARD</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>UNKNOWN MAKI</u>				14. MOTHER'S MAIDEN NAME <u>Edla HYVONEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT Address <u>Daughter - ELIZ. NYE - SAME AS #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm, ruptured, rt. internal carotid artery</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-31</u> , 19 <u>66</u> , to <u>9-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>66</u> , and that death occurred at <u>8:22 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Francis J. Mayle Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Mayle Jr. M. D.</u>				22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>9-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS</u>				25a. REC'D BY REGISTRAR <u>5130 WIS. AVE., N.W. WASHINGTON, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15028

CONTINUED OF DATA

15028

ALL DATA IN THIS SECTION ARE
BASED ON A SINGLE ANALYSIS OF
THE SAMPLES. THE RESULTS ARE
NOT MEANT TO BE USED FOR
COMPARISON WITH OTHER DATA
OR FOR THE DETERMINATION OF
TRENDS OR PATTERNS.

1
M
1
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in approval, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12993

CERTIFICATE OF DEATH

12987

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>RT # 3 Penfield</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>E</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1880</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Lee Martin</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Son above</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia</u> DUE TO (b) <u>Pyelonephritis</u> DUE TO (c) <u>Benign Prostate hyperplasia - obstructed</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 yrs</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable Myocardial Infarction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/6/1966</u> to <u>9/6/1966</u> , that (I) (we) last saw the deceased alive on <u>9/6/1966</u> , and that death occurred at <u>11:25 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert K. Macon</u>		22b. DATE SIGNED <u>9/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>9/9/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>George R. Swonder</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15003

RECORD OF WORK

10000

①

RECORD OF WORK
10000
15003

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12996

12988

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>7 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5616 OGDON RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEANOR C. MATTINGLY</u> First Middle Last			4. DATE OF DEATH <u>Sept 7 1966</u> Month Day Year				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1894</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BETHESDA MD. MONTGOMERY</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Charles C. Bohrer</u>				
14. MOTHER'S MAIDEN NAME <u>Annie R. Hodges</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>217-32-2172B</u>			17. INFORMANT <u>R. L. Mattingly - husband - same item #2</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>uremia, urine retention, dehydration</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>RAILROAD</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 19 59</u> , to <u>9/7 19 66</u> , that (I) (we) last saw the deceased alive on <u>9/6 19 66</u> and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Charles Savarese, MD</u>			22b. DATE SIGNED <u>9/7/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE, MD</u>			22d. ADDRESS <u>1125 Rockville Pike, Rockville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>			
23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>		24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> <u>1331 Rockville Pike</u> <u>Rockville, Maryland</u>					
25a. REC'D BY REGISTRAR DATE <u>SEP 8 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12988									
12989									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Gaston</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>56 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gastonia</u>			d. STREET ADDRESS <u>304 West 10th Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Maryland</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Barbara</u>			First Middle Last <u>(NMN) McArver</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 May 1945</u>		9. AGE (In years last birthday) <u>21</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger E. McArver</u>					14. MOTHER'S MAIDEN NAME <u>Helen Hall</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>243-70-0447</u>		17. INFORMANT <u>The Medical Records,</u> <u>The Clinical Center, Bethesda 14, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas Septicemia</u> <u>2924</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pelvic abscess from perforated colon</u> DUE TO (c) <u>Aplastic anemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 - 5 months</u> <u>17 months</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <u>U</u> (this hospital) attended the deceased from <u>22 July</u> , 19 <u>66</u> , to <u>16 September</u> , 19 <u>66</u> , that <u>U</u> (we) last saw the deceased alive on <u>16 September 1966</u> , and that death occurred at <u>11:05 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Leonard H. Brubaker</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>17 Sept. 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Leonard H. Brubaker, M.D.</u>			22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>			23b. DATE THEREOF <u>9-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gastonia Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Gastonia, No. Carolina</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

80231

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>23 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garroll Hall San. 96131 Garroll Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Caroline E. McCauley</u>		4. DATE OF DEATH <u>Sept. 8, 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1889</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rolph E. Dittus</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Gugel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing home records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Chronic myocardial infarction</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers M.D.</u>		22. DATE SIGNED <u>Sept. 8, 1966</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St NE.</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15038

15038

Dist. of Cal.

County of Los Angeles

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

City of Los Angeles

Office of the City Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Illinois b. COUNTY Sangamon	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 47 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) National Institutes of Health The Clinical Center, Bethesda, Maryland		e. STREET ADDRESS 2530 Lowell Avenue	
3. NAME OF DECEASED (Type or print) Mary Ann (none) McClain		4. DATE OF DEATH September 11 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 December 1947
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None School	11. BIRTHPLACE (County & State, or foreign country) Illinois
13. FATHER'S NAME James Junior McClain		14. MOTHER'S MAIDEN NAME Marion B. Wright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 2048 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Leukemia, lymphoblastic DUE TO (c) Meningeal leukemia, impacted right lower wisdom tooth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 days 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 July , 1966, to 11 Sept. , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 Sept. , 1966, and that death occurred at 3:25M , from the causes and on the date stated above.			
22a. SIGNATURE Leonard H. Brubaker		22b. DATE SIGNED Sept. 11, 1966	
22c. PHYSICIAN'S NAME (Type) Leonard H. Brubaker, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14, 1966	
23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery		23d. LOCATION (City, town or county) (State) Springfield, Illinois	
24. FUNERAL DIRECTOR Clark E. Wison Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR 4434 Georgia Ave. Silver Spring, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 14 1966	

MEDICAL CERTIFICATION

12891

12891

James H. Hester, M.D.
The Clinical Center, Bethesda, Md.
10 December 1947
Dear Sir:
Enclosed for you are two copies of a report on the results of the study of the effect of the administration of a certain drug on the blood sugar level of patients with diabetes mellitus. The study was conducted by Dr. Hester and Dr. H. H. Hester, Jr., and the results are presented in the report. The report is being submitted to you for your information and for your use in the clinical center. The report is being submitted to you for your information and for your use in the clinical center. The report is being submitted to you for your information and for your use in the clinical center.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12992

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3104 CHEVERLY AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH GEORGE MCGOWAN JR.</u>		4. DATE OF DEATH Month Day Year <u>SEPT 4 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 26 - 1948</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH GEORGE MCGOWAN Sr.</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA FUCHS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220 46 5971</u>	
17. INFORMANT <u>JOSEPH GEORGE MCGOWAN (FATHER)</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE Injuries.</u> DUE TO (b) <u>Trauma from Auto Accident.</u> DUE TO (c) <u>5 min?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of car he was driving + turned over.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:45 a.m. 9/4 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Belt Way 495</u>	20f. (City or town) (County) (State) <u>Bethesda Montgomery Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/4/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 9 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15991

15992

15993

15994

15995

15996

15997

15998

15999

16000

16001

16002

16003

16004

16005

16006

16007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G381 9/26/66 pc

CERTIFICATE OF DEATH

12993

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDUSTEY 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. NAVAL HOSPITAL		d. STREET ADDRESS BOX 66	
3. NAME OF DECEASED (Type or print) First Middle Last PRISCILLA (NMN) MERVOSH		4. DATE OF DEATH Month Day Year SEPTEMBER 18 19 66	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 JAN 1927
9. AGE (In years last birthday) 44 3/4 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MIKE VUYANOVICH		14. MOTHER'S MAIDEN NAME DOROTHY BASSAR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT SAMUEL MERVOSH		Address BOX 66, INDUSTRY, PENNSYLVANIA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) METASTATIC CANCER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MARCH 30 , 19 66 , to SEPT. 18 , 19 66 , that (I) (we) last saw the deceased alive on SEPT. 18 , 19 66 , and that death occurred at 1:00 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Carl Paul Kessler</i>		22b. DATE SIGNED SEPT. 18. 1966	
22c. PHYSICIAN'S NAME (Type) C. P. KESSLER		22d. ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Sept. 21, 1966	23c. NAME OF CEMETERY OR CREMATORY BEAVER CEMETARY	23d. LOCATION (City or Town) (County) (State) BEAVER BEAVER PA.
24. FUNERAL DIRECTOR <i>Robert G. Rumpke Funeral Home</i> SCHWERHA FUNERAL HOME		25a. REC'D BY REGISTRAR SEP 20 1966	
ADDRESS Bethesda Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1888

1888

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13000

CERTIFICATE OF DEATH

12994

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>2000 F. ST. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Meyers</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/94</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Jacob Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Ann Farley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1914-1919</u>		16. SOCIAL SECURITY NO. <u>493-24-6071</u>		17. INFORMANT <u>BLANCHE B MEYERS</u> Address <u>2000 F-STN.W. WASH, D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Syndrome</u> DUE TO <u>Chronic Emphysema</u> DUE TO <u>Chronic Myocardial</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 M</u> <u>5 yrs</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>Sept 26, 1966</u> that (I) (we) last saw the deceased alive on <u>9-25</u> 19 <u>66</u> , and that death occurred at <u>4:00</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Oliver E Thompson</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Oliver E Thompson</u>				22d. ADDRESS <u>901 Pershing Dr SE Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>FT MYER VA</u>	
24. FUNERAL DIRECTOR <u>W.C. CHAMBERS CO.</u>				ADDRESS <u>1400 CHAPIN ST WASH. DC</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1458

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12995

13001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~There~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>9709 Dilston Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Schreiber</u> Last <u>Middleton</u>				4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-24</u>	9. AGE (In years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager Safeway Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Albert Middleton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Schreiber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW-2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's Chart.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>165X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(metastases)</u> DUE TO (c) <u>Proven - Washington Hosp Center July 66</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-27</u> , 19 <u>66</u> to <u>—</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> , 19 <u>66</u> , and that death occurred at <u>10:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Gilbert B. Cushner</u> M.O.				ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GILBERT B. CUSHNER</u>				22d. ADDRESS <u>6480 N.H. Ave TK. PK. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Attwood</u> <u>3603 14th St NW</u> <u>Wash DC</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Cleared by Medical Examiner
Dr. John Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13002

CERTIFICATE OF DEATH

12996

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in lb <u>30 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		d. STREET ADDRESS <u>1916 Fox Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Milam</u>		4. DATE OF DEATH Month Day Year <u>9 10 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-91</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Adrienne Booth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Eugenia Milam Adelphi, Md.</u>		Address <u>1916 Fox St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute G-I bleeding</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma Calcium</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="radio"/> (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Sept 10</u> , 19 <u>66</u> , that (1) <u>we</u> last saw the deceased alive on <u>Sept 10</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>R. H. Sandstrom</u>		22b. DATE SIGNED <u>9-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u>		22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept. 13-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or town) (County) (State) <u>Lidge Rd. & Lees Rd. Md.</u>	
24. FUNERAL DIRECTOR <u>John T. ...</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1966</u>	
ADDRESS <u>254 Carroll St N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

74951

€0091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>13002</p> <p>MONTGOMERY</p> </div> <div> <p>MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>12997</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN b. 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boys d. STREET ADDRESS RFD # 1, Box 165 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last Miller					4. DATE OF DEATH Month Sept. Day 4 Year 19 66				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1892		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas W. Jacobs					14. MOTHER'S MAIDEN NAME Amanda Johnston				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Ellen M. Burdette, Address Item 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive - Cardio-vascular - Renal Disease DUE TO (b) Chronic - Acute - and DUE TO (c) to H.C.U.R. Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug. 28, 1966 to Sept. 4, 1966 , that (I) (we) last saw the deceased alive on Sept. 3, 1966 , and that death occurred at 2:10 a.m. , from the causes and on the date stated above.									
22a. SIGNATURE Jack Schumacher					22b. DATE SIGNED 9-6-66		22c. PHYSICIAN'S NAME (Type) Jack Schumacher, M.D.		
22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 7, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Ft. Myer, Va.		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.					25a. REC'D BY REGISTRAR SEP 8 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge		

1200

1200

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "1200" are visible at the top.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

139

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13004					CERTIFICATE OF DEATH			12998	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Lau. & Hospital</u>					d. STREET ADDRESS <u>4804 Somerset Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ollie</u> Middle <u> Mae</u> Last <u>Miller</u>					4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-1906</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Frank B. Rhymes</u>					14. MOTHER'S MAIDEN NAME <u>Vivian Terry</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>457 34 9128</u>		17. INFORMANT <u>PT's chart</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive metastases to lungs</u> DUE TO (c) <u>Carcinomatous from right breast ca</u>								INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>2 mos</u> <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> to <u>Sept 10</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Sept 10</u> , 19 <u>66</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>W. B. Eastman</u>					22b. DATE SIGNED <u>Sept 11, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Francis Gasch's Sons</u>		
22d. ADDRESS <u>4739 Balto</u>					22e. REC'D BY REGISTRAR <u>SEP 14 1966</u>				
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>			23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>									

18008

18008

18008

18008

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP 2

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13005

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DoA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comau manner</u>		16.7	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4311 Lawrence St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Leonard</u> Last <u>Mahlysh</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/23/12</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Sub. San.</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Leonard Mahlysh</u>		14. MOTHER'S MAIDEN NAME <u>Elsie P. Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-109125</u>		17. INFORMANT <u>7210 Semmes Rd. Rockville, Md. Richard L. Jenkins</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>431X</u> DUE TO <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Richard L. Jenkins</u> M.D.				22. DATE SIGNED <u>Sept 9, 1966</u>			
EXAMINER'S NAME (Type) <u>John S. Rogers M.D.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>1919 Semmes Rd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Com.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's</u> <u>Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier</u> <u>Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

PAGE 1

2022

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 8506 GREENWOOD AVE. #4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY HARVEY MOORE		4. DATE OF DEATH SEPT. 22 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-04
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC JACKSON MOORE		14. MOTHER'S MAIDEN NAME SUSAN R. MILES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 578-14-5615	
17. INFORMANT MRS DOROTHY DEGEORGE		Address 9405 CEALA ST. S.S., MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 4291 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) accompanied by generalized metastatic DUE TO (c) bronchogenic carcinoma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. Address (Street, city, town, or county) 9-23-1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep. 26, 1966	
23c. NAME OF CEMETERY OR CREMATORY Burtonsville, Union Cem.		23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland	
24. FUNERAL DIRECTOR C. Glen Carter		25a. REC'D BY REGISTRAR SEP 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

1074-7170

FOR STATE
HEALTH DEPT.

13008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13002

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DO.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8540 - 11th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES EUGENE MYERS</u>		4. DATE OF DEATH <u>9 29 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claims adjuster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motor Co.</u>	9. AGE (In years last birthday) <u>40</u>
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Myers</u>		14. MOTHER'S MAIDEN NAME <u>Alice McClure</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>577 30 4405</u>	
17. INFORMANT <u>Mrs. Helen Myers (wife)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary artery heart disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>George Walter, 257 Canal St. N.W. 4C</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13005

20052

ST. MARY
TOWN, N.J.

ST. MARY'S CHURCH
TOWN, N.J.
RECEIVED
JAN 10 1964
ST. MARY'S CHURCH
TOWN, N.J.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13007

13001

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS</u>		d. STREET ADDRESS <u>11536 HIGHVIEW AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>Lelia F MULLINS</u>		4. DATE OF DEATH <u>Sept. 9 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 7, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>81</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John J. Goolsby</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Virginia Koontz</u>		1536 Address <u>Highview Avenue Wheaton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive heart failure</u> DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1966</u> , to <u>Sept 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 6, 1966</u> , and that death occurred at <u>6:42 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr Joseph P. Kenrick</u>		22b. DATE SIGNED <u>9/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR JOSEPH KENRICK</u>		22d. ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Inscalooosa, Alabama</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		25a. RECD BY REGISTRAR DATE <u>SEP 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13001

13001



Form with multiple sections and fields, including a large redacted area at the top center. The form contains various headings and sub-sections, but the text is mostly illegible due to blurring and redaction. The form is divided into several horizontal sections by lines. There are two black circular marks on the right side of the page.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13003

13003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>22 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>				d. STREET ADDRESS <u>1221 Garland Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>(NMN)</u> Last <u>Nelson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-05</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Johannes</u>				14. MOTHER'S MARDEN NAME <u>Elna Harting</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Washington San & Hosp Records - Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of gall bladder</u> 1551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>8-13</u> , 19 <u>66</u> to <u>9-4</u> , 19 <u>66</u> , that (1) <u>(we)</u> last saw the deceased alive on <u>9-4</u> , 19 <u>66</u> , and that death occurred at <u>2:55</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				22d. ADDRESS <u>831 University Blvd. E., Silver Spring, Md.</u>			
23a. BURIAL-CREATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Sept 7-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Rd Prince Georges</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St. N.W.</u> <u>W.D.</u> <u>Takoma Park, Md. 21212</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

130013

OFFICE OF THE SECRETARY OF DEFENSE

130013

1. The purpose of this report is to provide a summary of the results of the research conducted during the period from 1 January 1961 to 31 December 1961. The research was conducted in the field of the study of the effects of the environment on the human body.

2. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

3. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

4. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

5. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

6. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

7. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

8. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

9. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

10. The research was conducted in the field of the study of the effects of the environment on the human body. The research was conducted in the field of the study of the effects of the environment on the human body.

FOR STATE
HEALTH DEPT.

13010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13004

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 505 Tulip Avenue	
3. NAME OF DECEASED (Type or print) First Henrietta Middle E. Last New		4. DATE OF DEATH Month 9 Day 28 Year 66	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 87 yrs.
11. BIRTHPLACE (State or foreign country) Morrisville, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham E. Hamilton		14. MOTHER'S MAIDEN NAME Margaret June Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William F. New		Address (Street, city, town, or county) 731 Basley Street Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion with left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ventricular rupture, hemopericardium and DUE TO (c) cardian tamponade.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. READ, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Oct. 1, 1966	
23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia	
24. FUNERAL DIRECTOR Janet Watters		25a. REC'D BY REGISTRAR OCT 3 1966	
25b. REGISTRAR'S SIGNATURE John H. Jones		22. DATE SIGNED 9-28-1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13011

13005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days / 12 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>Hartford St., Franklin Manor</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Garess</u> Middle <u>NMN</u> Last <u>Nicony</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-94</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Nicony</u>		14. MOTHER'S MAIDEN NAME <u>Net Licon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>154-12-7011</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary embolism</u> DUE TO <u> </u> (c) <u>Arteriosclerotic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>MO</u> <u>XRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anterior Carcinoma of Bladder</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERWAY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
21. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	22. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	24. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 22, 1966</u> to <u>Sept 3, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 2, 1966</u> , and that death occurred at <u>6 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.		22b. DATE SIGNED <u>9/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN, MD</u>		22d. ADDRESS <u>1106 SPRING ST</u> <u>314 VER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	23b. DATE THEREOF <u>9-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Howland</u>	23d. LOCATION (City or Town) (County) (State) <u>Howland</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. DATE <u>SEP 7 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13002

STATEMENT OF WORK

13011

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>12300 Middle Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maria Ondrejko</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>25</u> - Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-16</u> 9. AGE (In years last birthday) yrs. <u>49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Netherlands</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Zirkzee</u>		14. MOTHER'S MAIDEN NAME <u>Mary VanDenreiden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>John M. Ondrejko - HUSB.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. DATE SIGNED <u>9-25-1966</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 29, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Purphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13006

13006

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of" are faintly visible.]

[Faint handwritten text at the bottom of the page, including what appears to be a date "9-22-1966" and other illegible markings.]